Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11522	A. BUILDING _____ B. WING _____	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKEY ASSISTED LIVING	**3900 W OAKEY BLVD, LAS VEGAS, NEVADA ,89102**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
RFG 0000- No Deficiencies	The Statement of Deficiencies was generated as a result of a state licensure survey conducted in your facility, in accordance with Nevada administrative code, chapter 449, and Nevada revised statutes chapter 449- Residential Facility for Groups (RFG), medical facilities and other related entities. The findings and conclusions of any investigation by the Division of Health Care Purchasing and Compliance shall not be construed as prohibiting any criminal civil investigation, actions or other claims for reliefs that may be available to any party under applicable federal, state or local law. The RFG was found to be in substantial compliance. No regulatory deficiencies were identified. No further action is necessary. Inspector Comments: This Statement of Deficiencies was generated as a result of a complaint investigation initiated at your facility on 11/24/25 and finalized on 01/29/26. The census at the time of the survey was 85. The sample size was five. There were two complaints investigated. Substantiated without deficient Practice: 1. Complaint #12598 was substantiated with no deficient practice. 2. Complaint #12606 was substantiated with no deficient	RFG 0000- No Deficiencies		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11522	A. BUILDING _____ B. WING _____	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKEY ASSISTED LIVING	3900 W OAKEY BLVD, LAS VEGAS, NEVADA ,89102

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	practice. The investigation of Complaints included: Observation of physical appearance for residents, and a tour of the facility. Interviews were conducted with residents, Caregivers, MedTech's, the Resident Care Coordinator and the Administrator. Clinical Record Review of four records, which included the residents of concern. Document Review included facility policy and procedures, and incident reports.			