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 _____	04/21/2026

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OAKEY ASSISTED LIVING	3900 W OAKEY BLVD, LAS VEGAS, NEVADA ,89102

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RFG 0001-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. Based on an inspection conducted, the items marked below identify the violation in operation of the RFG which must be corrected by the revisit/compliance date specified in writing by the health authority. Failure to comply with this notice and immediately correct the identified deficiencies may result in the suspension or termination of your provider agreement, funding, or future authorization as a provider authorized by the State	RFG 0001-Deficiencies		

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	of Nevada pursuant to NAC 433.384, and other applicable local and state laws. Inspector Comments: This Statement of Deficiencies was generated as a result of a complaint investigation initiated at your facility on 02/09/26 and completed at your facility on 04/21/26. The census at the time of the survey was eighty-three. The sample size was seven. The facility received a grade of B. There was one complaint investigated. Substantiated: 1. Complaint # NV00012826 was substantiated. (See Tags 556, 590, 850 and 965) The investigation of the complaint included: Observation of resident to resident and caregiver to resident interactions, resident room security, and tour of the facility. Interviews with residents, Caregivers, the Senior Business Director, the Resident Experience Director (the Former Memory Care Director), and the Assistant to the General Manager. Clinical Record Review of 7 records, including the resident of concern. Document review of resident files, incident reports, Communication Logs, and facility policies.			
Y 0556 SS= H	NAC 449.262 and R043-22	Y 0556	**1)** We have corrected the specific findings for future similar events by having all employees in Memory Care take the online	05/25/2026

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	2. If an employee of the facility suspects that a resident is being abused, neglected, isolated or exploited, the employee shall report that fact in the manner prescribed in NRS 200.5093. Inspector Comments: Based on record review, document review and interview, the facility failed to ensure allegations of abuse were reported within 24 hours to Adult Protective Services (APS) as described in Nevada Revised Statutes (NRS) 200.5093 for two residents (Resident #11 and Resident #12). Findings include: Resident #11 (R11) R11 was admitted to the facility on 09/25/25 with a diagnosis of dementia. R11 was discharged on 01/08/26. A facility incident report dated 10/16/25 with the classification of Behavior-sexual documented R11 was inappropriate by touching R16's body. R16 told R11 many times to stop touching them. When Caregivers told R1 to leave R16 alone, R11 got aggressive and told Caregivers they could not tell them what to do and threatened to hit them with a 2x4 board. The incident report documented R11's physician and relative and the facility supervisor were notified. The incident report lacked documented evidence APS was notified. A facility incident report dated 10/18/25 at 6:36 AM with the incident classification of Behavior-sexual documented R11 went into R18's room while they were in bed and wanted to sleep with R18. R18 told R11 to get out; when the Caregiver told R11 to not go into R18's room because they didn't like it, R11 yelled and became very aggressive with the Caregiver and threatened them. The incident report documented R11's physician and relative and the facility		**Elder Abuse (Adult Protected Services) training program** and test through **Nevada Care Connections (**Copy Attached**)**. A certificate is generated only if the employee passes the test. **2)** We have put into place systematic changes that we hope will keep Elder Abuse at the top of our staffs' minds. We have implemented an **Elder Abuse Reporting Policy & Report Form (**both Copies Attached**)** that will be used at all Orientations and ongoing training sessions throughout the facility. **3)** We will monitor these corrective changes by Ownership and Administrative management who will be attending unannounced Orientations and training programs to verify Elder Abuse topics are covered continuously throughout the facility departments. **4)** The Administrator will be responsible for ensuring the POC will be implemented. **5)** May 25, 2026 **6)** Document #'s 1, 2, & 3	

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	supervisor were notified. The incident report lacked documented evidence APS was notified. A facility incident report dated and timed 10/18/25 at 3:06 PM with the incident classification of Behavior-sexual documented R11 was bothering and being touchy with R13 who did not feel comfortable. R11 tried to transfer R13 from their wheelchair to their chair and was stopped by the Caregiver because this could cause R13 to fall and have an injury. The incident report documented R11's relative and the facility supervisor were contacted, and the facility supervisor would notify R11's physician. The incident report lacked documented evidence APS was notified. A facility incident report dated 10/26/25 at 6:30 AM, incident classified as Behavior-resident to resident altercations, documented R15 came to the Caregivers and led them back to their room where they found R11 was in R15's bed. R15 reported that R11 had yanked them out of bed. When the Caregivers tried to get R11 out of R15's room, R11 took their shoes and was ready to strike at the Caregivers. After a while the Caregivers were able to redirect R11 and locked all resident rooms. The incident report documented the facility supervisor was called. The incident report lacked documented evidence APS was notified. A facility incident report dated 11/04/25, incident classified as verbal, documented R11 was found in R14's room and when the Caregiver asked R11 to leave, R11 refused and started to make hitting gestures. The Caregiver left to get assistance from another Caregiver and R11 took the opportunity to close the door to R14's room with R14 and R17 in the room. R11 kept R14 and R17 hostage in the room for over an hour until R11's family members came and were able to get R11 out of the room. Police were called to assist but were canceled since the family member was able to get R11 to open the door. The incident report documented R11's relative and the			

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	facility supervisor were notified. The incident report lacked documented evidence that APS was notified. A facility incident report dated and timed 12/05/25 at 12:53 documented R11 did not want R17 to go with the nurse to get blood work performed. R11 got aggressive with the nurse and would not let go of R17's hand until two caregivers intervened to get R17 inside their room. The incident report lacked documented evidence APS was notified. A facility incident report dated 12/11/25, incident classification Safey Concern, documented R11 went inside R20's room, closed the door, and wouldn't let Caregivers go in to check on R20. R11 blocked the door and got aggressive towards Caregivers, not letting them go inside. Once Caregivers were able to open the door, R11 had their pants and underwear down, and had defecated in R20's kitchen. The incident report documented R11's physician and relative and facility supervisor were notified. The incident report lacked documented evidence APS was notified. On 12/31/25 the facility submitted a report to APS (APS Intake #454870), which was more than 24 hours of when ADSD should be notified of suspected abuse. The suspected abuse was reported by residents, a resident's relative, and staff starting on 10/16/25. The report documented the facility was aware of the pattern off sexual behaviors directed at females by R11 starting two months prior. The report was filed by the Memory Care Director, and documented R11's sexual inappropriateness and aggression to female residents and staff and the resulting tension on the unit. On 02/09/26, Employee #8 (E8) verbalized the facility had not contacted Adult Protective Services (APS) every time R11 had an incident of inappropriate behavior. On 02/09/26, Employee #4 (E4) said they did not think the facility reported every incident of suspected sexual abuse to APS.			

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	Resident #12 (R12) R12 was admitted on 10/24/25 with a diagnosis of dementia. R12 was discharged on 12/05/25. A facility Communication Log dated 12/02/25 Night Shift documented R12 tried to have intercourse with R7. When the Caregiver went into the room, R12's pants and underwear were down. R12 did not want to go to their own room. The Caregiver changed R7 and locked their room. R12's file lacked documented evidence of a facility incident reported to APS regarding the incident. A facility Communication Log dated 12/04/25 Day Shift documented: R12 was on top of R6 who was saying, "Stop, stop" just when the Caregiver walked in from another resident's room from showering that resident. R12 was touching and wandering around to get to any of the female residents, in particular R13 and R16. Later R12 had R13 in between R12's legs sitting down. The Communication Log lacked documented evidence APS was notified of the incidents. A facility incident report dated and timed 12/04/25 at 5:33 PM documented R12 insisted on taking R15 to their room after dinner and was told, No. The incident report documented R12's physician and relative and the facility supervisor were notified. A different facility Incident/Accident Report dated and timed 12/04/25 at 5:33 PM documented the same event. The report, filled out by hand, documented that while in the dining area, R12 kept insisting on taking R15 to their room and the resident kept saying, No, No. R12 continues to pull out the wheelchair from the table to attempt to wheel R15 to the resident's room. The Caregiver noticed it and stopped R12 immediately. R12 was upset and stormed off to R12's room. R12's physician was contacted and their instructions were to send R12 out. Paramedics came but R12's Power of Attorney declined to send R12 out			

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	from the facility. The incident report was completed by a Caregiver and the Memory Care Director. The incident report lacked documented evidence APS was notified of the incident. Regarding incident reports, Employee #4 (E4) verbalized that the Incident Report should document who they contacted. On 02/09/26 in the afternoon, Employee #8 (E8) indicated the facility did not call APS every time R12 exhibited inappropriate behaviors. On 02/09/26 in the afternoon, Employee #4 (E4) shared that they did not think the facility reported abuse every time. The facility policy The facility Living Elder Abuse Prevention and Reporting Policy, revised June 1, 2024, documented: Under NRS 200.5093, all facility staff are mandated reporters and must report suspected abuse within 24 hours of discovery. Staff must immediately report to: · Administrator/Director (or designee) · Adult Protective Services · Law enforcement if the resident is in immediate danger or a crime is suspected. An undated facility document titled Completing an Incident/Accident Report (Manually) documented: All incidents related to physical abuse, neglect, sexual assault, or exploitation were reported to the Ombudsman (ADSD), and in the case of assault (Physical or sexual) would be reported to law enforcement. Severity: 3 Scope: 2 Complaint #NV00012826			
Y 0590 SS= H	NAC 449.268 **Rights of residents; procedure for filing grievance, complaint or report of incident;**	Y 0590	**1)** Although Residents #11 & #12 have been discharged from the facility for several months now, we have corrected the specific findings for future similar events by having a **Wellness Check Policy** which states the female MC residents are checked on twice as much as the male residents. Women's	05/25/2026

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	investigation and response. 1. The administrator of a residential facility shall ensure that: (a) The residents are not abused, neglected or exploited by a member of the staff of the facility, another resident of the facility or any person who is visiting the facility; (b) A resident is not prohibited from speaking to any person who advocates for the rights of the residents of the facility; (c) The residents are treated with respect and dignity; (d) The facility is a safe and comfortable environment; (e) Residents are not prohibited from interacting socially; (f) Residents are allowed to make their own decisions whenever possible; (g) Residents are aware that they may file a complaint or grievance with the administrator and that a resident who files such a complaint receives a response in a timely manner; (h) A resident is informed as soon as practicable that he is being moved to a new room or that he is receiving a new roommate; and (i) Residents are afforded the opportunity to initiate an advance directive or power of attorney for health care and that the employees of the facility comply with the wishes contained in such a document. 2. The administrator of a residential facility shall provide a procedure to respond immediately to grievance, incidents and complaints. The procedure must include a method for ensuring that the administrator or a person designated by the administrator is notified of the grievance, incident or complaint. The administrator or a person designated by the administrator shall		rooms are checked hourly, and men's rooms every two hours at the most (Copy of Policy Attached). **2)** We have put into place systematic changes like the QR Code Tracking System that can help caregivers keep track that the needs of our vulnerable residents are being met shift by shift. **3)** We will monitor these corrective changes by the MC Director & the Administrator verifying the QR Code print-out sheets that all policy requirements were completed the day before. We will also implement a **Behavioral Incident Report** that is specific to incidents that are more behavioral in nature so we can identify problems before they become worse. **4)** The Administrator will be responsible for ensuring the POC will be implemented. **5)** May 25, 2026 **6)** Document #'s 4,	

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	personally investigate the matter. A resident who files a grievance or complaint or reports an incident pursuant to this subsection must be notified of the action taken in response to the grievance, complaint or report or be given a reason why no action needs to be taken. 3. The employees of the facility shall comply with the procedures adopted pursuant to subsection 2. Inspector Comments: Based on interview and record review, the Administrator failed to ensure 9 of 19 female residents (Resident #7, #10, #13, #14, #15, #16, #17, #18, #19 and #20) were free from sexual and physical abuse from two male residents (Resident #11 and #12) who resided in the Memory Care Unit. Findings include: Resident #11 (R11) R11 was admitted to the memory care unit on 09/26/25 with a diagnosis of dementia and discharged on 01/08/26. A facility incident report dated 10/16/25 with the classification of Behavior-sexual documented R11 was inappropriate by touching R16's body. R16 told R11 many times to stop touching them. When caregivers told R11 to leave R16 alone R11 got aggressive and told caregivers they could not tell them what to do and threatened to hit them with a 2x4 board. A facility incident report dated 10/18/25 at 6:36 AM with the incident classification of Behavior-sexual documented R11 went into a R18's room while they were in bed and wanted to sleep with R18. R18 told R11 to get out, when the caregiver told R11 to not go into R18's room because they didn't like it, R11 yelled and became very aggressive with the caregiver and threatened them.			

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	A facility incident report dated and timed 10/18/25 at 3:06 PM with the incident classification of Behavior-sexual documented R11 was bothering and being touchy with R13 who did not feel comfortable. R11 tried to transfer R13 from their wheelchair to their chair and was stopped by the Caregiver because this could cause R13 to fall and have an injury. A facility incident report dated 10/26/25 at 6:30 AM incident classified as behavior - resident to resident altercations documented R15 came to the Caregivers and led them back to their room where they found R11 was in R15's bed. R15 reported that R11 had yanked them out of bed. When the Caregivers tried to get R11 out of the R15's room, R11 took their shoes and was ready to strike at the Caregivers. After a while the Caregivers were able to redirect R11 and locked all resident rooms. A facility incident report dated 11/04/25 incident classified as verbal documented R11 was found in R14's room and when the Caregiver asked R11 to leave R11 refused and started to make hitting gestures. The Caregiver left to get assistance from another Caregiver and R11 took the opportunity to close the door to R14's room with R14 and R17 in the room. R11 kept R14 and R17 hostage in the room for over an hour until R11's family member came and was able to get R11 out of the room. Police were called to assist but were canceled since the family member was able to get R11 to open the door. A facility Communication Log dated 11/15/25 documented R11 and R12 were up the whole night with an attitude, trying to open R7 and R13's doors to their rooms. The log documented a family member of R19 requested the facility to keep R11 away from R19 because R19 told the family member R11 tried to scare them. A facility incident report dated and timed 12/05/25 at 12:53 PM documented R11 did not want R17 to go with the nurse to get blood work performed. R11 got aggressive with the nurse and would not let go of R17's			

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	hand until two Caregivers intervened to get R17 inside their room. A facility incident report dated and timed 12/05/25 at 10:17 PM documented R11 was told to stay away from R17. R11 yelled and cursed at the Caregivers and tried to hit one of them. R11 also went inside R15's room. A facility incident report dated 12/11/25 incident classification Safety concern, documented R11 went inside R20's room, closed the door, and wouldn't let Caregivers go in to check on R20. R11 blocked the door and got aggressive towards Caregivers, not letting them go inside. Once Caregivers were able to open the door, R11 had their pants and underwear down, and had defecated in R20's kitchenette. A facility incident report dated and timed 12/31/25 at 10:15 AM documented R11 was touching R16's chest and holding their hand. R11's file documented a 30-day discharge notice dated 10/27/25 sent to R11's Power of Attorney for financial reasons informing them R11 would be discharged no later than 11/26/25 due to R11's behaviors that continually compromise the health and safety of residents and employees of the facility. R11's file documented a 30-day discharge notice dated 11/23/25 sent to R11's Power of Attorney for financial reasons informing them R11 would be discharged no later than 12/23/25 due to R11's behaviors that were being addressed by numerous Psychiatric Medical professionals with little success. The facility could not manage the behaviors that continually compromise the health and safety of residents and employees of the facility. An Advanced Practice Registered Nurse (APRN) assessment dated 12/4/25 documented R11 had increasingly become a safety risk to other residents. Based on ongoing concerns the APRN strongly recommended R11 be transferred to a geriatric psychiatric unit for further			

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	evaluation and stabilization. R11's 09/26/25 and 11/19/25 Care Plans documented R11 was only a wandering risk which required supervision and redirection from staff to prevent wandering episodes. R11's Care Plans lacked documented evidence of how the facility would prevent or manage R11's abusive or aggressive behaviors. On 04/21/26 in the morning, R11's file lacked documented evidence of a behavior plan to prevent, manage, and respond to R11's ongoing abusive behaviors. Resident #12 (R12) R12 was admitted on 10/24/25 with a diagnosis of dementia. R12 was discharged on 12/05/2025. A facility Communication Log dated 11/6/25 Night Shift documented R12 had been trying to transfer R13 and did transfer R7 to a recliner in the room. The note documented staff were to keep an eye on R12. A facility Communication Log dated 11/8/25 Night Shift documented R12 was yelling and telling the Caregiver to shut up when the Caregiver told R12 not to touch R14. A facility Communication Log dated 11/11/25 (Night Shift) documented R12 was very volatile, had an attitude, and tried to go to R13's room. A facility Communication Log dated 11/16/25 Day Shift documented R12 went into R7's room with instructions for the Caregivers to keep the door locked to ensure R12 would not go in R7's room. A facility Communication Log dated 12/02/25 Night Shift documented R12 tried to have intercourse with R7. When the Caregiver went into the room, R12's pants and underwear were down. R12 did not want to go to their own room. The Caregiver changed R7 and locked their room.			

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	A Communication Log dated 12/04/25 Day Shift documented R12 was on top of R6 who was saying “Stop, stop” just when the Caregiver walked in from another resident’s room. The same Communication Log documented R12 was touching and wandering around to get any of the female residents, in particular R13 and R16, then later R12 had R13 in between R12’s legs sitting down. A facility incident report dated and timed 12/04/25 at 5:33 PM documented while R12 was in the dining area, R12 kept insisting on taking R15 to their room and the resident kept saying No, No. R12 continued to pull out the wheelchair from the table to attempt to wheel R15 to their room. The Caregiver noticed it and stopped R12 immediately. R12 was upset and stormed off to R12’s room. R12’s physician was contacted and their instructions were to send R12 out to the hospital. An Adult Mental Health Crisis Packet dated 12/05/25 at 11:00 AM completed by a Nurse Practitioner/Physician Assistant documented: R12 had multiple incidents of sexual assault on multiple residents and presented a danger to other residents of bodily harm. One resident repeated they were not able to consent last night and was sexually assaulted (R15). Another resident yelled and staff intervened. At the current location R12 was a present danger to other residents of bodily harm. Potential harm to self if behavior was not controlled. R7’s family had requested closer supervision of R7 for their safety starting on 12/5/25 due to R12 going into R7’s room several times leaving clothing in the room. R7’s physician ordered hourly checks to ensure safety. Family installed a camera to monitor the situation. Rooms would have signs that read “No Men Allowed in women’s rooms;” the sign was used to alert staff to keep the male residents out of female rooms. R12 was alerted about not going into female rooms. R12’s 10/24/25 Care Plan documented R12			

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	11522	A. BUILDING _____ B. WING _____	04/21/2026

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	was only a wandering risk which required supervision and redirection from staff to prevent wandering episodes. R12's Care Plan lacked documented evidence of how the facility would prevent and manage R12's abusive behaviors. On 04/21/26 in the morning, R12's file lacked documented evidence of a behavior plan to prevent, manage, and respond to R12's ongoing abusive behaviors. In an interview on 02/09/26 at 1:15 PM, E9 verbalized that R12 wandered around, went into other residents' rooms, and got verbally upset at Caregivers. E9 shared that R11 was a wanderer, and was found in a female resident's room, sleeping on their couch. Per E9, R11 was verbally and physically aggressive, and would throw shoes. E9 reported that residents' families gave the facility permission to lock the doors to their rooms, because the families knew the facility could not stop R11 and R12 from wandering. On 02/09/26 at 1:25 PM, E10 reported a Caregiver had come out from showering a resident when another resident started screaming, "Help me; Get off me!" R12 was on top of R6. E10 verbalized R12 did a lot of inappropriate touching with female residents and was aggressive. E10 explained in order to keep residents safe, the Caregivers would take any perpetrator out for a walk. They would close and lock the doors to other residents' rooms and all Caregivers carried keys to the residents' rooms. E10 described a time when R12 wheeled R13 down the hall towards the entrance doors, saying R12 would take the resident for a walk. When R12 was down the hall R12 was found to be rubbing R13's legs under their dress. E10 told R12 they could not do that and R12 got upset, saying, "Why can't we do it if we're adults?" Consequently, R13 put their dress down, and the two of them stopped. E10 wheeled R13 back from the hallway.			

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	E10 reported R12 would also try to take R13 to their room. R13 didn't like their door closed, but the Caregivers told R13 the door had to be locked because otherwise R12 would try to get in. On 02/09/26 at 4:40 PM, E4 explained that R12 started off sweet, soft, not aggressive. R12 did not become aggressive until the very end. R12's provider reported R12 needed a higher level of care. E4 reported that R12 told facility staff that R12 wanted a female, so facility staff spoke to R12's relatives who asked for urge-reducing medications. R12 started the medication on 12/03/25 and 12/04/25, but the medications were not working and R12 continued to follow female residents. On 02/09/26 in the afternoon, E8 reported that on 12/04/26, two incidents occurred involving R12: 1) R12 was on top of R6, who was screaming, "Stop, Stop," and pushing R12 off just when a Caregiver walked into the room. 2) R12 had a female resident cornered in the dining room and was trying to go in between their legs, and Care Staff tried to pull them apart. In a phone interview on 03/30/26, the Facility Consultant acknowledged R11 and R12's behavior was annoying to female residents who didn't want the advances. The facility did not do one-on-one surveillance with R11 and R12; they were treated in the same way all the other residents were. The Facility Consultant explained that the memory care unit only had 20 units, so it was not too hard to keep an eye on everyone. On 04/21/26 in the morning, E8 verbalized the facility had not assigned either R11 or R12 a one-on-one Caregiver and verbalized reaching out to peers for advice on how to manage R11 and R12's behaviors. On 04/21/26 in the morning, the Facility Consultant acknowledged the facility had not assigned a one-on-one Caregiver for either R11 or R12. According to the Facility			

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	Consultant, the facility was not sure what to do with R11 and R12. In a phone interview on 03/30/26, the Administrator stated they had no idea whether or not 30-minute or 1-hour checks were conducted on the memory care unit, and that normally, they would conduct 2-hour checks for all the residents. The Administrator did not know the protocol regarding the facility Communication Log. The Administrator admitted that they had not personally spoken with the families of residents on the memory care unit, nor to the Ombudsman. The Administrator reported that everything they had regarding the incidents surrounding R11 and R12 was hearsay. Severity: 3 Scope: 2 Complaint # NV00012826			
Y 0850 SS= D	NAC 449.274 and R043-22 **Medical care of resident after illness, injury or accident; periodic physical examination of resident; rejection of medical care by resident; written records.** 1. If a resident of a residential facility becomes ill or is injured, the resident's physician and a member of the resident's family must be notified at the onset of illness or at the time of the injury. The facility shall: (a) Make all necessary arrangement to secure the services of a licensed physician to treat the resident if the resident's physician is not available; and (b) Request emergency services when such services are necessary. 2. A resident who is suffering from an illness or injury from which the resident is expected to recover within 14 days after the onset of the illness or the time of the injury	Y 0850	**1)** We have corrected the specific findings by having Managers hold specific Incident Report discussions that have dramatically cut down on the number of errors that had been spotted in past Incident Reports, and also when to call APS (**Adult Protective Services**) to file a complaint (see copy of Elder Abuse, et al, Remedies Guide attached). **2)** We have put into place systematic changes that will highlight signs of Elder Abuse. These **Common Signs & Indicators of Abuse** will help staff understand the importance of reporting what they saw or believe happened to a resident. As mandated reporters, it is important to know when an Incident Report highlights a cause of Elder Abuse, and when it is to be just an Incident Report or a call to APS as a Elder Abuse complaint. It is always better to be safe than sorry and report according to the "triggers" of reporting (copy of Common Signs that should Trigger an APS Report in NV). **3)** We will monitor these corrective changes by the Memory Care Management	05/25/2026

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	may be cared for in the facility. The decision as to the period within which the resident is expected to recover from the illness or injury and the needs of the resident must be made by the resident's physician or, if he is unavailable, by another licensed physician. 3. A written record of all accidents, injuries and illnesses of the resident which occur in the facility must be made by the caregiver who first discovers the accident, injury or illness. The record must include: (a) The date and time of the accident or injury or the date and time that the illness was discovered; (b) A description of the manner in which the accident or injury occurred or the manner in which the illness was discovered; (c) A description of the manner in which the members of the staff of the facility responded to the accident, injury or illness and the care provided to the resident. This record must accompany the resident if he or she is transferred to another facility. 4. The facility shall ensure that appropriate medical care is provided to the resident by: (a) A caregiver who is trained to provide that care; (b) An independent contractor who is trained to provide that care; or (c) A medical professional. 5. Before admission and each year after admission, or more frequently if there is a significant change in the physical condition of a resident, the facility shall obtain the results of a general physical examination of the resident by a qualified provider of health care in accordance with NRS 449.1845. The resident must be cared for pursuant to any instructions provided by the qualified provider of health care. 6. The members of the staff of the facility shall: (a) Ensure that the resident receives the personal care that he requires. (b) Monitor the ability of the resident to care for his own health conditions and shall document in writing any significant change in his ability to care for those conditions. 7. This section does not prohibit a resident from rejecting medical care. If a resident rejects medical care, an employee of the facility shall record the rejection in writing		continuously pointing out potential abuse scenarios during each shift. It is important to keep Elder Abuse on top of mind so that all staff feel safe that they can recognize abuse as well as know how and when to report it. **4)** The Administrator will be responsible for ensuring the POC will be implemented. **5)** May 25, 2026 **6)** Documents Attached	

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	and request that the resident sign that record as a confirmation of his rejection of medical care. If the resident rejects medical care that a physician has directed the facility to provide, the facility shall inform the resident's physician of that fact within 4 hours after the care is rejected. The facility shall maintain a record of the notice provided to the physician pursuant to this subsection. 8. As used in this section, "significant change" means a change in a resident's condition that results in a category 1 resident becoming a category 2 resident or otherwise results in an increase in the level of care required by the resident. Inspector Comments: Based on record review, interview, and document review, the facility failed to ensure an incident report was completed after a resident (Resident #12) was found being sexually inappropriate towards another resident. Findings include: Resident #12 (R12) R12 was admitted on 10/24/25 with a diagnosis of dementia. A facility Communication Log dated 12/02/25 Night Shift documented R12 tried to have intercourse with R7. When the Caregiver went into the room, R12's pants and underwear were down. R12 did not want to go to their own room. The Caregiver changed R7 and locked their room. R12's file lacked documented evidence of a facility incident report regarding the incident. An undated facility document entitled "Completing an Incident/Accident Report (Manually)" documented: It was very important that a complete and accurate Incident/Accident Report was completed as soon as possible after an			

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	occurrence, so that all Management was aware of the situation. In a phone interview on 03/30/26 at 10:44 AM, Employee #6 (E6) indicated the facility Communication Log was not considered an Incident Report. The Communication Log was for shift to shift relay of messages. Per E6, an Incident Report would be required for an occasion of assault. In a phone interview on 03/30/26 at 11:15 AM, Employee #8(E8) verbalized the facility Communication Log was not used as an Incident Report. Per E8, if there was an assault, Staff were expected to report it to a supervisor immediately, and fill out an Incident Report. Severity: 2 Scope: 1 Complaint # NV00012826			
Y 0965 SS= H	**NAC 449.2754** **Residential facility which provides care to persons with Alzheimer's disease: Application for endorsement; general requirements.** 3. The administrator of such a facility shall prescribe and maintain on the premises of the facility a written statement which includes: (a) The facility's policies and procedures for providing care to its residents; (b) Evidence that the facility has established interaction groups within the facility which consist of not more than six residents for each caregiver during those hours when the	Y 0965	**1)** We have corrected the specific findings by initiating a **Behavior Support & Safety Plan** when potentially dangerous behaviors are exposed (see copy attached). We will initiate this Plan when it is discovered that a potentially dangerous behavior might be evolving. **2)** We have put into place systematic changes that will assist in identifying abusive and sexual behaviors, especially through retraining and Policy and Plans that our staff can depend upon (see Y0556, Y0590, and Y0850 attachments). We have also initiated our **Change of Condition Report** to better identify the numerous changes that can occur in a Resident (see attachment copy #9). **3)** We will monitor these corrective changes by utilizing all of the materials available to train our staff in recognizing potential Elder Abuse, and particularly reportable Elder Abuse to APS, or the Police, and giving our	05/25/2026

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	residents are awake; (c) A description of: (1) The basic services provided for the needs of residents who suffer from dementia; (2) The activities developed for the residents by the members of the staff of the facility; (3) The manner in which behaviors will be managed; (4) The manner in which medication for residents will be managed; (5) The activities that will be developed by the members of the staff of the facility to encourage the involvement of family members in the lives of the residents; and (6) The steps the members of the staff of the facility will take to: (I) Prevent residents from wandering from the facility; and (II) Respond when a resident wanders from the facility; and (d) The criteria for admission to and discharge and transfer from the facility. 4. The written statement required pursuant to subsection 3 must be available for review by residents of the facility, members of the staff of the facility, visitors to the facility and the bureau. 5. The administrator shall ensure that the facility complies with the provisions of the statement required pursuant to subsection 3. Inspector Comments: Based on interview and record review, the facility 1) Failed to develop and implement behavior plans to		staff the materials and supervision they need and will depend upon so they can proceed with confidence in preventing Abuse. **4)** The Administrator will be responsible for ensuring the POC will be implemented. **5)** May 25, 2026 **6)** Document Attached	

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	prevent, manage, and respond to the ongoing abusive behaviors of two male residents and ensure resident safety (Resident #11 and Resident #12) and 2) Failed to update the individualized care plans of two residents with ongoing abusive behaviors in the Memory Care Unit (Resident #11 and Resident #12). Findings include: Resident #11 (R11) R11 was admitted to the memory care unit on 09/26/25 with a diagnosis of dementia and discharged on 01/08/26. A facility incident report dated 10/16/25 with the classification of Behavior-sexual documented R11 was inappropriate by touching R16's body. R16 told R11 many times to stop touching them. When caregivers told R11 to leave R16 alone R11 got aggressive and told caregivers they could not tell them what to do and threatened to hit them with a 2x4 board. A facility incident report dated 10/18/25 at 6:36 AM with the incident classification of Behavior-sexual documented R11 went into a R18's room while they were in bed and wanted to sleep with R18. R18 told R11 to get out, when the caregiver told R11 to not go into R18's room because they didn't like it, R11 yelled and became very aggressive with the caregiver and threatened them. A facility incident report dated and timed 10/18/25 at 3:06 PM with the incident classification of Behavior-sexual documented R11 was bothering and being touchy with R13 who did not feel comfortable. R11 tried to transfer R13 from their wheelchair to their chair and was stopped by the caregiver because this could cause R13 to fall and have an injury. A facility incident report dated 10/26/25 at 6:30 AM incident classified as behavior - resident to resident altercations documented R15 came to the Caregivers and led them back to their room where they found R11 was in R15's bed. R15 reported			

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	that R11 had yanked them out of bed. When the caregivers tried to get R11 out of the R15's room, R11 took their shoes and was ready to strike at the caregivers. After a while the caregivers were able to redirect R11 and locked all resident rooms. A facility incident report dated 11/04/25 incident classified as verbal documented R11 was found in R14's room and when the caregiver asked R11 to leave R11 refused and started to make hitting gestures. The caregiver left to get assistance from another caregiver and R11 took the opportunity to close the door to R14's room with R14 and R17 in the room. R11 kept R14 and R17 hostage in the room for over an hour until R11's family member came and were able to get R11 out of the room. Police were called to assist but were canceled since the family member was able to get R11 to open the door. A facility Communication Log dated 11/15/25 documented R11 and R12 were up the whole night with an attitude, trying to open R7 and R13's doors to their rooms. The log documented a family member of R19 requested the facility to keep R11 away from R19 because R19 told the family member R11 tried to scare them. A facility incident report dated and timed 12/05/25 at 12:53 PM documented R11 did not want R17 to go with the nurse to get blood work performed. R11 got aggressive with the nurse and would not let go of R17's hand until two caregivers intervened to get R17 inside their room. A facility incident report dated and timed 12/05/25 at 10:17 PM documented R11 was told to stay away from R17. R11 yelled and cursed at the Caregivers and tried to hit one of them. R11 also went inside R15's room. A facility incident report dated 12/11/25 incident classification Safety concern, documented R11 went inside R20's room, closed the door, and wouldn't let Caregivers go in to check on R20. R11 blocked the door and got aggressive towards Caregivers, not letting them go inside. Once			

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	Caregivers were able to open the door, R11 had their pants and underwear down, and had defecated in the R20's kitchenette. A facility incident report dated and timed 12/31/25 at 10:15 AM documented R11 was touching R16's chest and holding their hand. R11's file documented a 30-day discharge notice dated 10/27/25 sent to R11's Power of Attorney for financial reasons informing them R11 would be discharged no later than 11/26/25 due to R11's behaviors that continually compromise the health and safety of residents and employees of the facility. R11's file documented a 30-day discharge notice dated 11/23/25 sent to R11's Power of Attorney for financial reasons informing them R11 would be discharged no later than 12/23/25 due to R11's behaviors that were being addressed by numerous Psychiatric Medical professionals with little success. The facility could not manage the behaviors that continually compromise the health and safety of residents and employees of the facility. An Advanced Practice Registered Nurse (APRN) assessment dated 12/4/25 documented R11 had increasingly become a safety risk to other residents. Based on ongoing concerns the APRN strongly recommended R11 be transferred to a geriatric psychiatric unit for further evaluation and stabilization. R11's 09/26/25 and 11/19/25 Care Plans documented R11 was only a wandering risk which required supervision and redirection from staff to prevent wandering episodes. R11's Care Plans lacked documented evidence of how the facility would prevent or manage R11's abusive or aggressive behaviors. On 04/21/26 in the morning, R11's file lacked documented evidence of a behavior plan to prevent, manage, and respond to R11's ongoing abusive behaviors. Resident #12 (R12)			

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	R12 was admitted on 10/24/25 with a diagnosis of dementia. R12 was discharged on 12/05/2025. A facility Communication Log dated 11/6/25 Night Shift documented R12 had been trying to transfer R13 and did transfer R7 to a recliner in the room. The note documented staff were to keep an eye on R12. A facility Communication Log dated 11/8/25 Night Shift documented R12 was yelling and telling the Caregiver to shut up when the Caregiver told R12 not to touch R14. A facility Communication Log dated 11/11/25 (Night Shift) documented R12 was very volatile, had an attitude, and tried to go to R13's room. A facility Communication Log dated 11/16/25 Day Shift documented R12 went into R7's room with instructions for the Caregivers to keep the door locked to ensure R12 would not go in R7's room. A facility Communication Log dated 12/02/25 Night Shift documented R12 tried to have intercourse with R7. When the Caregiver went into the room, R12's pants and underwear were down. R12 did not want to go to their own room. The Caregiver changed R7 and locked their room. A Communication Log dated 12/04/25 Day Shift documented R12 was on top of R6 who was saying "Stop, stop" just when the Caregiver walked in from another resident's room. R12 was touching and wandering around to get any of the female residents, in particular R13 and R16, then later R12 had R13 in between R12's legs sitting down. A facility incident report dated and timed 12/04/25 at 5:33 PM documented while R12 was in the dining area, R12 kept insisting on taking R15 to their room and the resident kept saying No, No. R12 continued to pull out the wheelchair from the table to attempt to wheel R15 to their room. The Caregiver noticed it and stopped R12 immediately.			

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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
	R12 was upset and stormed off to R12's room. R12's physician was contacted and their instructions were to send R12 out to the hospital. An Adult Mental Health Crisis Packet dated 12/05/25 at 11:00 AM completed by a Nurse Practitioner/Physician Assistant documented: R12 had multiple incidents of sexual assault on multiple residents and presented a danger to other residents of bodily harm. One resident repeated they were not able to consent last night and was sexually assaulted (R15). Another resident yelled and staff intervened. At the current location R12 was a present danger to other residents of bodily harm. Potential harm to self if behavior was not controlled. R7's family had requested closer supervision of R7 for their safety starting on 12/5/25 due to R12 going into R7's room several times leaving clothing in the room. R7's physician ordered hourly checks to ensure safety. Family installed a camera to monitor the situation. Rooms would have signs that read "No Men Allowed in women's rooms;" the sign was used to alert staff to keep the male residents out of female rooms. R12 was alerted about not going into female rooms. R12's 10/24/25 Care Plan documented R12 was only a wandering risk which required supervision and redirection from staff to prevent wandering episodes. R12's Care Plan lacked documented evidence of how the facility would prevent and manage R12's abusive behaviors. On 04/21/26 in the morning, R12's file lacked documented evidence of a behavior plan to prevent, manage, and respond to R12's ongoing abusive behaviors. On 04/21/26 in the morning, E8 verbalized R11 and R12's Care Plans had likely not been updated and should have been. On 04/30/26 in the morning, the Facility Consultant confirmed the facility failed to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	update R11 and R12's Care Plans to include their abusive behaviors and acknowledged no behavior plans were ever developed or implemented for R11 and R12. Facility Psychiatric Decompensation Policy dated 07/11/18 documented Caregivers were to report a change in the resident's personality or behavior to the on-duty Medication Technician, Wellness Director or Executive Director as appropriate……. The Service Plan is updated or amended to reflect any change in care needs. Severity: 3 Scope: 2 Complaint# 12826			