STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10448	A. BUILDING _____ B. WING _____	06/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKMONT OF THE LAKES	3250 S. FORT APACHE ROAD, LAS VEGAS, NEVADA ,89117

(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 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 completed in your facility on 06/23/26. The census at the time of the survey was 128. The sample size was five. The facility received a grade of A. There was one complaint investigated. Substantiated without deficient practice: 1. Complaint #NV13657 was substantiated with no deficient practice. The investigation of the Complaint included: Observation of narcotic counts, medication storage, and a tour of the facility. Interviews were conducted with residents, Medication Technicians, the Health Services Director and the Executive Administrator. Clinical Record Review of five records, which included the resident(s) of concern. Document Review included facility policy and procedures, medication management training, the facility's investigation of missing narcotics and the facility's controlled drug administration records.			
Y 0850 SS= E	NAC 449.274 and R043-22	Y 0850	1. Oakmont Management Group's Policy was	07/01/2026

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	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 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		reviewed regarding Unusual Occurrence Reporting and Incident Reporting 2. An in-service was conducted for the staff that would be submitting an Unusual Occurrence Report and Incident Report Training as well. See attached 3. Both Health Services Director and Executive Director will confirm whether an Unusual Occurrence Report needs to be filed and complete if necessary 4. Executive Director to monitor and review incidents to see if Incident Reports and Unusual Occurrences Reports are needed	

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	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 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 interview and document review, the facility failed to comply with their established policies and procedures regarding incident reporting subsequent to a report of missing narcotics for 2 of 5 residents. (Resident #1 and Resident #2) Findings include:			

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	Resident #1 (R1) R1 was admitted on 02/13/26 with diagnoses including metabolic encephalopathy, bipolar disorder and depression. R1's file revealed an order dated 03/05/26 for Hydrocodone/APAP 10-325mg tab, take one tablet by mouth every 8 hours as needed for pain moderate, or severe pain. R1's file revealed a Medication Administration history relaying R1 was administered the Hydrocodone 121 times from 04/23/26-06/23/26. R1's Controlled Drug Administration Record revealed R1 was administered the Hydrocodone 79 times from 04/23/26-05/19/26. Resident #2 (R2) R2 was admitted on 03/17/26 with diagnoses of Alzheimer's disease and hypertension. R2's file revealed an order dated 04/02/26 for Hydrocodone/APAP 5-325mg tab, take one tablet by mouth every 12 hours as needed for severe pain. R2's file revealed a Medication Administration history relaying R2 was administered the Hydrocodone 6 times from 04/06/26-05/21/26. R2's Controlled Drug Administration Record revealed R2 was administered the Hydrocodone 4 times from 05/15/26-05/21/26. On 06/23/26 in the morning, R1 and R2's files lacked documented evidence of an incident report related to the missing hydrocodone medication. On 05/03/26 in the afternoon, a Medication Technician reported missing narcotics for two residents to the Resident Care Coordinator. The Resident Care Coordinator reported the missing narcotics to the Health Services Director and the Executive Director. The facility's medication administration process (undated) revealed any team			

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	member who witnesses an incident or unusual occurrence, was to fill out a report. The facility's controlled (scheduled) medication policy, dated December 2013, revealed at the end of each shift, all of the controlled substances would be counted and documented on the form Controlled Substance Shift Count. The policy revealed if there is a discrepancy in the count, the Supervisor was to be notified immediately if the medication was misappropriated. An Unusual Occurrence Report will be completed to document the discrepancy. On 06/23/26 in the morning, the Executive Director confirmed the facility had not completed an incident report or an Unusual Occurrence report, as required by facility policy. Severity:2 Scope: 2			