

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 11522	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER OAKEY ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 3900 W OAKEY BLVD, LAS VEGAS, NEVADA ,89102		
(X4) ID PREFIX TAG RFG 0001- Deficiencies	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG RFG 0001- Deficiencies	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER Name: PHILIP PRENTISS Title: Administrator
REPRESENTATIVE'S SIGNATURE

Date: 09/01/2026

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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 an annual survey and complaint investigation completed at your facility on 06/09/26. The facility is licensed for 92 Residential Facility for Group beds for elderly and disabled persons and/or Assisted Living Services, Category II residents and/or 20 Residential Facility for Group beds for elderly and disabled persons and/or Alzheimer's Disease, Category II residents. The census at the time of the survey was 93. The sample size was 21. The facility received a grade of A There were two complaints investigated. Substantiated: 1.Complaint #13811 was substantiated. (See Tags #0172, #0878, and #883) 2.Complaint #13794 was substantiated. (See Tags #878 and #0883) The investigation of the complaints included: Observation of grooming and appearance			

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	of residents, medication rooms, facility cameras, and a tour of the facility. Interviews were conducted with Residents, Caregivers, the Wellness Director, and the Consulting Administrator. Clinical Record Review of 21 records, which included the residents Medication Administration Record.			
Y 0172 SS= F	NAC 449.209 2. Containers used to store garbage outside of the facility must be kept reasonably clean and must be covered in such a manner that rodents are unable to get inside the containers. At least once each week, the containers must be emptied, and the contents of the containers must be removed from the premises of the facility. 3. Containers used to store garbage in the kitchen and laundry room of the facility must be covered with a lid unless the containers are kept in an enclosed cupboard that is clean and prevents infestation by rodents or insects. Containers used to store garbage in bedrooms and bathrooms are not required to be covered unless they are used for food, bodily waste or medical waste. 4. To the extent practicable, the premises of the facility must be kept free from: (a) Offensive odors; (b) Hazards, including obstacles that	Y 0172	1) We have corrected the specific findings by purchasing two mini fridges specifically for holding specimens of residents for later pick-up. 2) As this was a systematic change in our policy as well as purchasing additional hardware for implementation, the deficiency has been corrected and signage on the fridges state "for sample specimens only". 3) We will monitor the corrective actions by the lead medtechs verifying on their shifts that only specimens are held in these fridges. 4) The Care Director will be responsible for seeing the corrective actions are implemented. 5) 07/12/2026 6) See attached receipt for the specimen refrigerators.	06/12/2026

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	impede the freemovement of residents within and outside the facility; (c) Insects and rodents; and (d) Accumulations of dirt, garbage and other refuse. 5. The administrator of a residential facility shall ensure that the premises are clean and that the interior, exterior and landscaping of the facility are well maintained. Inspector Comments: Based on observation and interview, the facility failed to ensure the environment was free from hazards including infection control hazards associated with cross contamination. Findings include: On 06/09/26 in the morning, the refrigerators in the medication rooms for the memory care unit and the assisted living were observed. There was one refrigerator labeled "Medication Only" located in the memory care unit medication room and one refrigerator labeled "Medication Only" located in the assisted living medication room. On 06/09/26 in the morning, A medication Technician was interviewed and verbalized if they receive a urine specimen that needs refrigeration it would be placed in the same refrigerator as the refrigerated medications until the urine specimen was picked up for delivery by the laboratory. On 06/09/26 in the morning, the Wellness Director acknowledged the facility was			

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	required to have a separate refrigerator for the urine specimens and instructed the facility to purchase one specifically for urine specimens but did not know why these were not delivered and/or placed in the medication rooms. Severity: 2 Scope: 3 Complaint #13811			
Y 0515 SS= D	NAC 449.259 Supervision of residents. 1. A residential facility shall ensure that the staff of the facility collaborate with each resident of the facility, the family of the resident and other persons who provide care for the resident, including, without limitation, a qualified provider of health care, as interpreted by section 8 of this regulation, to: (a) Develop a person-centered service plan for the resident; and (b) Review the person-centered service plan at least once each year. 2. A person-centered service plan developed pursuant to this section must include, without limitation: (a) Provisions concerning activities of daily living, medication management, cognitive safety, assistive devices, special needs, social and recreational needs and involvement of ancillary services; (b) Protective supervision as necessary for the resident; (c) The manner in which all caregivers will be informed of the required supervision of the resident; (d) The manner in which the facility will ensure that the resident has the opportunity to attend the religious service of his or her choice and participate in personal and private pastoral counseling; (f) Permission for the resident to enter or leave the facility at any time if the resident: (1) Is physically and mentally capable of leaving the facility; and	Y 0515	1) We have corrected the specific finding by creating a new more detailed MC Resident Phone Use Policy and having the staff familiarize themselves with the Policy and sign that they have read it. 2) We have put into place these systematic changes so that future problems with Resident Cell Phone usage can be referenced within the Policy document. 3) We will monitor the corrective actions to ensure the deficient practice will not occur by having a copy of the Policy in the Med Room and all shift RCC's have a personal copy to reference if a problem should occur. 4) The Care Director will be responsible for seeing the corrective actions are implemented. 5) August 28, 2026 6) See attached Resident Phone Use Policy.	08/28/2026

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	(2) Complies with the rules established by the administrator of the facility for leaving the facility; (g) Laundry services for the resident unless the resident elects in writing to make other arrangements; (h) The manner in which the facility will ensure that the resident's clothes are clean, comfortable and presentable; (i) A requirement that the facility must inform the resident or his or her representative of the actions that the resident should take to protect the resident's valuables; (j) A written program of activities for the resident that includes scheduled and unscheduled activities that are suited to his or her interests and capacities; Inspector Comments: Based on interviews, record review and document review, the facility failed to develop a person-centered care plan that documented resident's behaviors and a plan to handle the behaviors for 1 of 21 residents (Resident #19). Resident #19 (R19) R19 was admitted to the facility on 04/04/26with a diagnosis of Dementia. On 06/09/26 in the morning, R19 verbalized wanting to have a cellular phone but the facility would not allow it. The facility's policy titled Resident Cell Phone documented memory care and cognitively impaired residents may continue to use personal devices when appropriate and safe. The management team may recommend limitations if device use creates significant			

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	confusion, distress, wandering risk, exploitation concerns, or safety issues. Any restrictions should be documented in the resident's care plan. On 06/09/26 in the morning the Resident Care Coordinator verbalized R 19 had behaviors such as using the cellphone and repeatedly calling 911 making false claims. R19's care plan lacked documented evidence of the behaviors as to why R19 was restricted from having a personal cell phone and a plan to ensure R19 could use a phone in a safe manner. The Resident Care Coordinator indicated due to R19's behaviors R19 was not allowed to have their own cellular phone but was allowed access to the facility phone. R19's care plan lacked documented evidence of any behaviors as to why R19 was restricted from having a personal cell phone. On 06/09/26 in the afternoon, the Resident Care Coordinator acknowledged the facility failed to follow their policy and procedure regarding cell phone use for cognitively impaired residents and verbalized R19's care plan should have been modified to ensure R19 could have had access to a cell phone. Severity: 2 Scope: 1 Complaint #13794			
Y 0878 SS= D	NAC 449.2742 5. An over-the-counter medication or a	Y 0878	1) We have corrected the specific findings by holding Med Mgt classes at Oakley specifically training on the Topics that we have been finding in our weekly Medication Cart Audits, which are being conducted by	07/20/2026

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	dietary supplement may be given to a resident only if the resident's physician , physician assistant or advanced practice registered nurse has approved the administration of the medication or supplement in writing or the facility is ordered to do so by another physician , physician assistant or advanced practice registered nurse. The over-the-counter medication or dietary supplement must be administered in accordance with the written instructions of the physician , physician assistant or advanced practice registered nurse. The administration of over-the-counter medications and dietary supplements must be included in the record required pursuant to paragraph (b) of subsection 1 of NAC 449.2744. 6. Except as otherwise provided in this subsection, a medication prescribed by a physician, physician assistant or advanced practice registered nurse must be administered as prescribed by the physician, physician assistant or advanced practice registered nurse.. If a physician, physician assistant or advanced practice registered nurse orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order; (2) Indicate on the container of the medication that a change has occurred; and (3) Note the change in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; (b) Within 5 days after the change is ordered, a copy of the order or prescription signed by the physician, physician assistant or advanced practice registered nurse must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; and (c) If the label prepared by a pharmacist does not match the order or prescription written by a physician, physician assistant or advanced practice registered nurse, a physician, registered nurse or pharmacist must interpret that order or prescription and, within 5 days after the change is ordered, the interpretation must be included in the record maintained pursuant to paragraph		the new Compliance Director who is responsible for pointing out the deficiencies found as well as verifying corrective actions have been taken. 2) We have put into place these systematic changes of multiple Medication Cart Audits, that are done weekly by the Compliance Director, to make sure past errors are not recurring. 3) We will monitor the corrective actions by the Compliance Director meeting weekly with the Administrator if any deficient findings are found in the Audits conducted that week. 4) The Care Director will be responsible for seeing the corrective actions are implemented. 5) July 20, 2026	

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	(b) of subsection 1 of NAC 449.2744. Inspector Comments: Based on observations, interviews and record reviews the facility failed to ensure medications were administered according to physicians' orders for 4 of 21 sampled residents. (Resident #14, #16, 18, and #19) Findings include: Resident #14 (R14) R14 was admitted on 02/27/26 and discharged on 06/01/26 with diagnoses including dementia and diabetes. R14's April 2026 MAR's and May 2026 MAR's documented R14 missed administration of medications and documented the reason for missing the medication administration as "waiting on meds" or "waiting on pharmacy". R14's record documented a physician's order for duloxetine HCL 30 milligrams, take one capsule by mouth two times daily for depression dated 03/03/26. R14's April 2026 MAR documented duloxetine HCL 30 milligrams, take one capsule by mouth two times daily for depression and was initialed as not being administered on 04/11/26 and 04/12/26 at 8:00 am and 5:00 pm, and documented the reason for missing the medication administration as "waiting on meds". R14's record documented a physician's order for carvedilol 25 milligrams, take one tablet by mouth two times daily for			

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	hypertension dated 02/28/26. R14's April 2026 MAR documented carvedilol 25 milligrams, take one tablet by mouth two times daily for hypertension and was initialed as not being administered on 04/26/26 at 5:00 pm and 04/27/26 at 8:00 am and 5:00 pm, and documented the reason for missing the medication administration as "waiting on meds". R14's record documented a physician's order for prochlorper 10 milligrams, take one tablet three times a day at breakfast/lunch/dinner dated 04/17/26. R14's May 2026 MAR documented prochlorper 10 milligrams, take one tablet three times a day at breakfast/lunch/dinner and was initialed as not being administered on 05/05/26 at 12:00 pm and 5:00 pm, and was initialed as not being administered on 05/06/26 at 7:00 am, 12:00 pm and 5:00 pm, and was initialed as not being administered on 05/08/26 at 7:00 am, and was initialed as not being administered 05/09/26 and 05/10/26 at 7:00 am, 12:00 pm and 5:00 pm, and documented the reason for missing the medication administration as "waiting on meds" or "waiting on pharmacy". R14's record documented a physician's order for losartan potassium 100 milligrams, take one tablet by mouth once daily for hypertension dated 04/16/26. R14's May 2026 MAR documented losartan potassium 100 milligrams, take one tablet by mouth once daily for hypertension and was initialed as not being administered on 05/05/26 at 12:00 pm and 5:00 pm, and was initialed as not being administered on 05/22/26, 05/23/26, 05/26/26, 05/30/26, and 05/31/26 at 8:00 am and documented the reason for missing the medication administration as "waiting on meds".			

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	Resident #16 (R16) R16 was admitted on 12/16/25 with diagnoses including stroke. R16's record revealed a faxed document labeled Warfarin (Coumadin) Dosing Letter dated 05/27/26 and signed by the VA anticoagulation clinics prescriber. The letter documented a change in the weekly Warfarin dosing to using Warfarin 2 milligram tablets and a grid dictating the number of tablets and milligrams to be given per the day of the week. The directions stated to give 2 tablets, 4 milligrams on Sunday, Tuesday, Wednesday, Thursday, Friday, and Saturday and give 1 tablet, 2 milligrams on Monday. R16's June 2026 Medication Administration Record (MAR) documented Warfarin 2 milligrams, take 1 tablet by mouth every Monday and Friday with a start date of 05/29/26. R16's June 2026 MAR documented Warfarin 2 milligrams, take 2 tablets by mouth every Sunday, Tuesday, Wednesday, Thursday, Friday, and Saturday with a start date of 05/28/26. R16's June 2026 MAR documented the Medication Technicians signed each entry as administered. R16 had medication packages on the medication cart labeled Warfarin 2 milligrams, take 1 tablet by mouth every Monday and Friday and medication packages on the medication cart labeled Warfarin 2 milligrams, take 2 tablets by mouth every Sunday, Tuesday, Wednesday, Thursday, Friday, and Saturday			

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	Resident #18 (R18) R18 was admitted 12/12/25 with diagnoses including hypertension and neuropathy. R18's record documented a physician's order for topiramate 200 milligram tablet, take one tablet by mouth twice daily dated 12/12/26. R18's April 2026 and May 2026 MAR documented topiramate 200 milligram tablet, take one tablet by mouth twice daily. R18's May 2026 MAR documented topiramate 200 milligrams, take one tablet by mouth twice daily was initialed as not being administered on 05/10/26 at 7:00 pm, and documented the reason for missing the medication administration as "need refill". R18's medication package was labeled topiramate 50 milligram tablet, take one tablet by mouth twice daily. R18's April 2026 MAR's and May 2026 MAR's documented R18 missed administration of medications related to the medication needing refill, waiting on medication, or medication unavailable. R18's record documented a physician's order for Hydralazine HCL 25 milligrams, take 3 tablets by mouth every 8 hours for hypertension dated 12/12/25. R18's April 2026 MAR documented Hydralazine HCL 25 milligrams, take 3 tablets by mouth every 8 hours for hypertension and was initialed as not being administered on 04/12/26 at 2:00 pm, and documented the reason for missing the medication administration as "waiting on meds".			

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	R18's record documented a physician's order for sodium bicarbonate 650 milligrams, take 2 tablets by mouth twice a day dated 03/08/26. R18's April 2026 MAR documented sodium bicarbonate 650 milligrams, take 2 tablets by mouth twice a day and was initialed as not being administered at 12:00 pm, and documented the reason for missing the medication administration as "waiting on meds". R18's record documented a physician's order for allopurinol 100 milligrams, take one tablet by mouth once daily dated 12/29/26. R18's May 2026 MAR documented allopurinol 100 milligrams, take one tablet by mouth once daily was initialed as not being administered on 05/26/26 at 8:00 am, and documented the reason for missing the medication administration as "no med". A medication error report dated 04/12/26 for R18 documented on 04/12/26, R18 missed their hydralazine and sodium bicarbonate administration as they were waiting on medications from the VA. Resident #19 (R19) R19 was admitted on 04/04/26 with diagnoses including dementia. R19's May 2026 MAR's documented R19 missed administration of medications and documented the reason for missing the medication administration as "waiting on meds" or "waiting on pharmacy". R19's record documented a physician's			

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	order for amlodipine 10 milligrams, take one tablet by mouth daily dated 04/04/26. R19's May 2026 MAR documented amlodipine 10 milligrams, take one tablet by mouth daily and was initialed as not being administered from 05/04/26 through 05/16/26 at 8:00 am and documented the reason for missing the medication administration as "waiting on meds" or "waiting on pharmacy". R19's May 2026 MAR documented on 05/11/26 "resident refused" the amlodipine, which would be inconsistent with the medication not being available six days prior and five days after that documentation. R19's record documented a physician's quetiapine 25 milligrams, take one tablet by mouth twice daily dated 04/04/26. R19's May 2026 MAR documented quetiapine 25 milligrams, take one tablet by mouth twice daily and was initialed as not being administered from 05/12/26 through 05/16/26 at 8:00 am and 5:00 pm and documented the reason for missing the medication administration as "waiting on meds" or "waiting on pharmacy". On 06/09/26 in the morning, the Medication Technician acknowledged R16's MAR and medication packaging did not match the current Warfarin Dosing Letter which indicated R16 was receiving the wrong dosage of Warfarin as prescribed. The Medication Technician verbalized they did not know why there was a discrepancy in R16's dosing and would clarify with the anticoagulation clinic and notify R16's physician. On 06/09/26 in the morning, the Wellness Director verbalized they were not aware of R16's Warfarin medication order discrepancy and would ensure the Warfarin orders were clarified through the anticoagulation clinic, R16's primary			

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	physician, and the pharmacy. On 06/09/26 in the morning, the Wellness Director acknowledged R18's topiramate medication package did not match R18's physician orders for topiramate and was getting the wrong dose of topiramate. On 06/09/26 in the morning, the Medication Technician verbalized the facility orders medication refills when a resident has eight doses remaining. The Medication Technician verbalized if a resident misses a dose of their medications, they document it on the MAR, notify the physician and family. The Medication Technician verbalized they would try to get a handwritten prescription (Hard Script) for the family to take to a pharmacy of their choice and pay to get the medication refilled. On 06/09/26 the Wellness Director and Consulting Administrator acknowledged R14, R18, and R19 had missed doses of their medication while waiting for refills from the pharmacy and acknowledged the process as verbalized by the Medication Technician. The Wellness Director and consulting Administrator verbalized that usually the payment was the issue between the pharmacy and the family when medication refills were not available. The Wellness Director and Consulting Administrator acknowledged medications for R14, R16, R18 and R19 were not administered per physicians' orders. No adverse outcomes were verbalized or recorded related to the R14, R16, R18 and R19 missed doses and/or wrong dosage given of the prescribed medications. Severity: 2 Scope: 1			

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	Complaint #13811 and 13794			
Y 0883 SS= D	NAC 449.2742 7. If a resident refuses, or otherwise misses, an administration of medication, a physician, physician assistant or advanced practice registered nurse must be notified within 12 hours after the dose is refused or missed. Inspector Comments: Based on interviews and record review the facility failed to ensure the physician was notified of missed medication administration for 3 of 21 sampled residents. (Resident #14, #18, and #19) Findings include: Resident #14 (R14) R14 was admitted on 02/27/26 and discharged on 06/01/26 with diagnoses including dementia and diabetes. R14's April 2026 MAR's and May 2026 MAR's documented R14 missed administration of medications and documented the reason for missing the medication administration as "waiting on meds" or "waiting on pharmacy". R14's record documented a physician's order for duloxetine HCL 30 milligrams, take one capsule by mouth two times daily for depression dated 03/03/26. R14's April 2026 MAR documented duloxetine HCL 30 milligrams, take one capsule by mouth two times daily for depression and was initialed as not being administered on 04/11/26 and 04/12/26 at	Y 0883	1) We have corrected the specific findings by having the Missed Medication Protocol in writing for all Medication Technicians to see and use. This Protocol will be a part of their on-going Medication training. Reports will be completed and sent prior to the 12-hour deadline. Using these reports and attaching to the fax copy or email copy that is used to send the notice is the easiest way to check on how well the system Protocol is being followed. 2) We have put into place systematic changes that will be the training meetings themselves, as we have made it easier to follow the procedure and to notify the PCP by having a written Report sent and a written Protocol available. 3) We will monitor the corrective actions by the Senior Residential Care Coordinator checking daily the ECP Program report that shows any missed medications. With that report, one can check off that a report was actually sent and would be the verifying last step. 4) The Care Director will be responsible for seeing the corrective actions are implemented. 5) 8/01/2026 6) See attached Documents	08/01/2026

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	8:00 am and 5:00 pm, and documented the reason for missing the medication administration as "waiting on meds". R14's record documented a physician's order for carvedilol 25 milligrams, take one tablet by mouth two times daily for hypertension dated 02/28/26. R14's April 2026 MAR documented carvedilol 25 milligrams, take one tablet by mouth two times daily for hypertension and was initialed as not being administered on 04/26/26 at 5:00 pm and 04/27/26 at 8:00 am and 5:00 pm, and documented the reason for missing the medication administration as "waiting on meds". R14's record documented a physician's order for prochlorper 10 milligrams, take one tablet three times a day at breakfast/lunch/dinner dated 04/17/26. R14's May 2026 MAR documented prochlorper 10 milligrams, take one tablet three times a day at breakfast/lunch/dinner and was initialed as not being administered on 05/05/26 at 12:00 pm and 5:00 pm, and was initialed as not being administered on 05/06/26 at 7:00 am, 12:00 pm and 5:00 pm, and was initialed as not being administered on 05/08/26 at 7:00 am, and was initialed as not being administered 05/09/26 and 05/10/26 at 7:00 am, 12:00 pm and 5:00 pm, and documented the reason for missing the medication administration as "waiting on meds" or "waiting on pharmacy". R14's record documented a physician's order for losartan potassium 100 milligrams, take one tablet by mouth once daily for hypertension dated 04/16/26. R14's May 2026 MAR documented losartan potassium 100 milligrams, take one tablet by mouth once daily for hypertension and			

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	was initialed as not being administered on 05/05/26 at 12:00 pm and 5:00 pm, and was initialed as not being administered on 05/22/26, 05/23/26, 05/26/26, 05/30/26, and 05/31/26 at 8:00 am and documented the reason for missing the medication administration as "waiting on meds". R14's record lacked documented evidence the physician was notified of the missed medication doses. Resident #18 (R18) R18 was admitted 12/12/25 with diagnoses including hypertension and neuropathy. R18's record documented a physician's order for topiramate 200 milligram tablet, take one tablet by mouth twice daily dated 12/12/26. R18's April 2026 and May 2026 MAR documented topiramate 200 milligram tablet, take one tablet by mouth twice daily. R18's medication package was labeled topiramate 50 milligram tablet, take one tablet by mouth twice daily. R18's May 2026 MAR documented topiramate 200 milligrams, take one tablet by mouth twice daily was initialed as not being administered on 05/10/26 at 7:00 pm, and documented the reason for missing the medication administration as "need refill". R18's April 2026 MAR's and May 2026 MAR's documented R18 missed administration of medications related to the medication needing refill, waiting on medication, or medication unavailable. R18's record documented a physician's			

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	order for Hydralazine HCL 25 milligrams, take 3 tablets by mouth every 8 hours for hypertension dated 12/12/25. R18's April 2026 MAR documented Hydralazine HCL 25 milligrams, take 3 tablets by mouth every 8 hours for hypertension and was initialed as not being administered on 04/12/26 at 2:00 pm, and documented the reason for missing the medication administration as "waiting on meds". R18's record documented a physician's order for sodium bicarbonate 650 milligrams, take 2 tablets by mouth twice a day dated 03/08/26. R18's April 2026 MAR documented sodium bicarbonate 650 milligrams, take 2 tablets by mouth twice a day and was initialed as not being administered at 12:00 pm, and documented the reason for missing the medication administration as "waiting on meds". R18's record documented a physician's order for sodium bicarbonate 650 milligrams, take 2 tablets by mouth twice a day dated 03/08/26. R18's record documented a physician's order for allopurinol 100 milligrams, take one tablet by mouth once daily dated 12/29/26. R18's May 2026 MAR documented allopurinol 100 milligrams, take one tablet by mouth once daily was initialed as not being administered on 05/26/26 at 8:00 am, and documented the reason for missing the medication administration as "no med". R18's record contained a medication error report dated 04/12/26 for R18 documented on 04/12/26, R18 missed their hydralazine			

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	and sodium bicarbonate administration as they were waiting on medications from the VA R18's May 2026 MAR documented topiramate 200 milligrams, take one tablet by mouth twice daily was initialed as not being administered on 05/10/26 at 7:00 pm, and documented the reason for missing the medication administration as "need refill". R18's record lacked evidence the physician was notified of the other missed medication doses. Resident #19 (R19) R19 was admitted on 04/04/26 with diagnoses including dementia. R19's May 2026 MAR's documented R19 missed administration of medications and documented the reason for missing the medication administration as "waiting on meds" or "waiting on pharmacy". R19's record documented a physician's order for amlodipine 10 milligrams, take one tablet by mouth daily, dated 04/04/26. R19's May 2026 MAR documented amlodipine 10 milligrams, take one tablet by mouth daily and was initialed as not being administered from 05/04/26 through 05/16/26 at 8:00 am and documented the reason for missing the medication administration as "waiting on meds" or "waiting on pharmacy". R19's May 2026 MAR documented on 05/11/26 "resident refused" the amlodipine, which would be inconsistent with the medication not being available six days prior and five days after that documentation. R19's record documented a physician's quetiapine 25 milligrams, take one tablet by mouth twice daily dated 04/04/26.			

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	R19's May 2026 MAR documented quetiapine 25 milligrams, take one tablet by mouth twice daily and was initialed as not being administered from 05/12/26 through 05/16/26 at 8:00 am and 5:00 pm and documented the reason for missing the medication administration as "waiting on meds" or "waiting on pharmacy". R19's record lacked documented evidence the physician was notified of the missed medication doses. On 06/09/26 in the morning,, The Medication Technician verbalized if a resident misses a dose of their medications, they document it on the MAR, notify the physician and family. On 06/11/26 via email communication, the Consulting Administrator acknowledged the missing medication administration doses and lack of medication error reports documenting the physician was notified of the missing medication administration doses. Severity: 2 Scope: 1 Complaint #13811			