DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**10/31/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER SKY AT DEER SPRINGS ASSISTED LIVING	**6741 N DECATUR BLVD BLDG #3, LAS VEGAS, NEVADA ,89130**

(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
0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of an annual State Licensure and Complaint survey completed at your facility on 10/31/23, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for 96 Residential Facility for Group beds (82 Category I and 14 Category II) to provide care for elderly or disabled persons and/or Assisted Living Services. The census at the time of the survey was 87. Twenty resident files and ten employee files were reviewed. The facility received a grade of C. There was one complaint investigated. Verified: Complaint #NV00069380 was verified. (See Tag 0276) The investigation of the complaint included: Observation of grooming and physical appearance of residents, meal observations, staff providing care, staff and resident interactions, and a tour of the facility. Interviews were conducted with residents, staff and family members of residents. Clinical Record Review of five residents. Document Review included menus, posted mealtimes and staff schedules. The findings and conclusions of any investigation by the Division of Public and Behavioral Health shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified:	0000		
0074 SS= D	Elder Abuse Training - NRS 449.093 Training to recognize and prevent abuse of older persons: Persons required to receive; frequency; topics; costs; actions for failure to complete. 1. An applicant for a license to operate a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day,	0074	1. Employee #9 completed Elder Abuse Awareness Training on 11/01/2023. Employee #9 also completed Nevada Care Connection Adult Protective Services Training on 11/06/2023. 2. Administrator will review and update Employee File Tracker on a monthly basis to ensure that all employees are current with Initial and Annual Elder Abuse	11/01/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | Name: HEATHER LANKFORD | Title: Administrator | Date: 11/15/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	residential facility for groups or home for individual residential care must receive training to recognize and prevent the abuse of older persons before a license to operate such a facility, agency or home is issued to the applicant. If an applicant has completed such training within the year preceding the date of the application for a license and the application includes evidence of the training, the applicant shall be deemed to have complied with the requirements of this subsection. 2. A licensee who holds a license to operate a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must annually receive training to recognize and prevent the abuse of older persons before the license to operate such a facility, agency or home may be renewed. 3. If an applicant or licensee who is required by this section to obtain training is not a natural person, the person in charge of the facility, agency or home must receive the training required by this section. 4. An administrator or other person in charge of a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must receive training to recognize and prevent the abuse of older persons before the facility, agency or home provides care to a person and annually thereafter. 5. An employee who will provide care to a person in a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must receive training to recognize and prevent the abuse of older persons before the employee provides care to a person in the facility, agency or home and annually thereafter. 6. The topics of		Training. Administrator will review New Employee files while they are on-boarding to the community and ensure that they have initial Elder Abuse Training. Administrator will ensure that Initial/Annual Elder Abuse Training Certificates are placed in employee file upon completion and Employee File Tracker is updated to reflect completion with new expiration date. 3. Administrator will review Employee File Tracker on a monthly basis. 4. Administrator will monitor for compliance. 5. 11/01/2023	

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	instruction that must be included in the training required by this section must include, without limitation: (a) Recognizing the abuse of older persons, including sexual abuse and violations of NRS 200.5091 to 200.50995, inclusive; (b) Responding to reports of the alleged abuse of older persons, including sexual abuse and violations of NRS 200.5091 to 200.50995, inclusive; and (c) Instruction concerning the federal, state and local laws, and any changes to those laws, relating to: (1) The abuse of older persons; and (2) Facilities for intermediate care, facilities for skilled nursing, agencies to provide personal care services in the home, facilities for the care of adults during the day, residential facilities for groups or homes for individual residential care, as applicable for the person receiving the training. 7. The facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care is responsible for the costs related to the training required by this section. 8. The administrator of a facility for intermediate care, facility for skilled nursing or residential facility for groups who is licensed pursuant to chapter 654 of NRS shall ensure that each employee of the facility who provides care to residents has obtained the training required by this section. If an administrator or employee of a facility or home does not obtain the training required by this section, the Division shall notify the Board of Examiners for Long-Term Care Administrators that the administrator is in violation of this section. 9. The holder of a license to operate a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care shall ensure that each person who is required to comply with the requirements for training pursuant to			

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	this section complies with such requirements. The Division may, for any violation of this section, take disciplinary action against a facility, agency or home pursuant to NRS 449.160 and 449.163. Inspector Comments: Based on interview and record review, the facility failed to ensure Elder Abuse training was completed annually for 1 of 10 employees (Employee #9). Findings include: Employee #9 was hired on 09/06/22 as the Executive Director. Review of Employee #9's employee records revealed Elder Abuse training was last completed on 09/06/22. There was no documentation Employee #9 completed Elder Abuse training after 09/06/22. On 10/31/23 in the morning, the Executive Director confirmed Employee #9 had not completed Elder Abuse training since 09/06/22. Severity: 2 Scope: 1			

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0102 SS= D	Personnel File - TB Screening - NAC 449.200 Personnel files. 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (d) The health certificates required pursuant to chapter 441A of NAC for the employee; Inspector Comments: Based on interview and record review, the facility failed to ensure a tuberculosis (TB) screening was completed annually for 1 of 10 employees (Employee #6). Findings include: Employee #6 was hired on 06/06/22 as a Medication Technician. Review of Employee #6's employee record revealed an initial 2 step TB screening was last completed on 06/06/22. Employee #6's file lacked documented evidence of an annual TB screening for 2023. On 10/31/23 in the morning, the Executive Director confirmed the last documented TB screening in the record of Employee #6 was dated 06/06/22. The facility did not provide documented evidence a TB screening was completed after 06/06/22 for Employee #6. Severity: 2 Scope: 1	0102	1. Employee #6 completed a new 2 Step TB Test on 11/10/2023. 2. Administrator will review and update Employee File Tracker on a monthly basis to ensure that all employees are current with Initial and Annual TB Testing requirements. Administrator will review New Employee files while they are on-boarding to the community and ensure that they have initial TB Testing. Administrator will ensure that Initial/Annual TB Testing requirements are placed in the employee file and the Employee File Tracker is updated to reflect completion with new expiration date. 3. Administrator will review Employee File Tracker on a monthly basis. 4. Administrator will monitor for compliance. 5. 11/10/2023	11/10/2023

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0106 SS= D	Personnel File - 1st Aid & CPR - NAC 449.200 Personnel files 2. The personnel file for a caregiver of a residential facility must include, in addition to the information required pursuant to subsection 1: (a) A certificate stating that the caregiver is currently certified to perform first aid and cardiopulmonary resuscitation; Inspector Comments: Based on interview and record review, the facility failed to ensure initial Cardiopulmonary Resuscitation (CPR) training was completed for 1 of 10 employees (Employee #3). Findings include: Employee #3 was hired on 06/20/23 as a Caregiver. Review of Employee #3's employee record lacked documented evidence of CPR training. On 10/31/23 in the morning, the Executive Director confirmed Employee #3 had no documentation CPR training was completed. Severity: 2 Scope: 1	0106	1. Employee #3 attended in person CPR/First Aid class on November 9, 2023. 2. Administrator will review New Employee files while they are on-boarding to the community and ensure that they have current CPR/First Aid training. If they do not have the training the Administrator will schedule them for a class, prior to being employed for 30 days. Administrator will ensure that current CPR/First Aid cards are placed in employee file upon completion and Employee File Tracker is updated to reflect completion with new expiration date. 3. Administrator will review Employee File Tracker on a monthly basis. 4. Administrator will monitor for compliance. 5. 11/09/2023	11/09/2023

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0255 SS= F	Permits-Comply with NAC 446 on Food Service - NAC 449.217 Kitchens; storage of food; adequate supplies of food; permits; inspections. (NRS 449.0302) 6. A residential facility with more than 10 residents shall: (a) Comply with the standards prescribed in chapter 446 of NAC; and (b) Obtain the necessary permits from the Division. Inspector Comments: Based on observation on 10/31/2023, the facility failed to ensure the kitchen and supportive dining services complied with the standards of NAC 446. Findings include: 1. Critical Violations: a. In the walk-in cooler, the following items were held longer than seven days after preparation: beef sauce on 10/04/23, beef gravy on 10/12/23, chicken teriyaki on 10/19/23 and gravy on 10/22/23. b. The high temperature dish machine did not reach the minimum 180 degrees Fahrenheit (F) for the final rinse after operating the machine through four cycles. 2. Major Violations: a. In the walk-in cooler, the following items were not labeled or dated: cooked rice, sliced tomatoes, pudding, breaded chicken and a beef stew. b. The floor was not sealed and was in a state of disrepair around the floor sink under the dish machine. 3. Equipment and Maintenance Violations: a. The filter on the ventilation hood above the dish machine was torn and in disrepair. Severity: 2 Scope: 3	0255	1. Food in the walk in that were held longer than 7 days and that were not labelled or dated were disposed of in the garbage on 10/31/2023.The dish machine was services on 11/08/2023 and is reaching the minimum of 180 degrees on the final rinse cycle.The filter on the ventilation hood above the dish machine was replaced. The floor near the floor sink under the dish machine has not been repaired. This has been identified as a major repair and we must get at least three estimates for the repair as the dish machine will have to be removed to make the repair. 2. Dietary staff have been educated and will continued to be monitored. 3. Director of Food and Dining will monitor for compliance. 4. Administrator and Director of Food and Dining will monitor for compliance. 5. 11/14/2023. Will get 3 quotes for floor repair by 11/30/2023.	11/30/2023

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0276 SS= F	Service of Food-Nutritious Meals;Frequency - NAC 449.2175 Service of food 7. Meals must be nutritious, served in an appropriate manner, suitable for the residents and prepared with regard for individual preferences and religious requirements. At least three meals a day must be served at regular intervals. The times at which meals will be served must be posted. Not more than 14 hours may elapse between the meal in the evening and breakfast the next day. Snacks must be made available between meals for the residents who are not prohibited by their physicians from eating between meals. Inspector Comments: Based on observation, document review and interview the facility failed to ensure a meal was served on time. Findings include: On 10/31/23 at 11:30 AM, residents were gathered at the front entrance of the dining area waiting to be seated for lunch. The mealtimes posted revealed lunch was from 11:30 AM to 1:00 PM. The doors to the dining area were opened at 11:36 AM and residents began to be seated. Residents began eating their meal at 11:40 AM. On 10/31/23 in the morning, a resident was in their room and verbalized that meals are often late and stated that last night's dinner was twenty minutes late. On 10/31/23 at 11:40 AM, a staff member acknowledged the dining area was opened late for lunch and stated they didn't know why the dining area was opened late. On 10/31/23 in the afternoon, the Administrator acknowledged the dining area should be available at the posted times. Severity: 2 Scope: 3	0276	1. Dietary staff will ensure that the dining room doors are open and ready for diners at the posted times. Staff were educated on the importance of being timely with dining hours. 2. Dietary staff education and reminders. 3. Director of Food and Dining will monitor for compliance. 4. Administrator of Director of Food and Dining will monitor for compliance. 5. 11/14/2023	11/14/2023
0878 SS= D	Medication/OTCS, Supplements, Change Order - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 5. An over-the-counter medication or a dietary supplement may be given to a resident only if the resident's physician has approved the administration of the	0878	1. On 11/06/2023 Physician discontinued Carvedilol and Clonidine for Resident #5. 2. Director of Wellness will review all Resident Medication orders on the MARS to ensure that there are no medications with parameters in place. MARS are reviewed on a monthly basis. Director of Wellness with review all new orders to ensure that	11/06/2023

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	medication or supplement in writing or the facility is ordered to do so by another physician. The over-the-counter medication or dietary supplement must be administered in accordance with the written instructions of the physician. 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 must be administered as prescribed by the physician. If a physician 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 (Previously Y 0879) (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 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, the 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 (b) of subsection 1 of NAC 449.2744. Inspector Comments: Based on interview and record review, the facility failed to ensure a medication was given as prescribed and was onsite for 1 of 20 residents (Resident #5). Findings include: Resident #5 (R5) was admitted on 06/23/22 with diagnosis including chronic heart failure and type 2 diabetes mellitus. Physician order for R5, dated 08/03/22, documented Carvedilol, 3.125 milligram		transcription from the order to the MARS is accurate. Director of Wellness will initial that they have reviewed all orders before they are filed in the Resident Record. 3. Director of Wellness and Med-Techs will double check that the order is parameter free. 4. Administrator and Director of Wellness will monitor for compliance. 5. 11/06/2023	

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	(MG) tablets, take one tablet by mouth two times a day as needed for blood pressure greater than 150 systolic, give with meals. Physician order for R5, dated 06/16/22, documented Clonidine 0.1 MG tablet, take one tablet by mouth every four hours as needed for hypertension, give when systolic blood pressure is over 180, by a specific family member. Review of the Medication Administration Record (MAR) for October 2023 documented Carvedilol and Clonidine to be given as needed for R5 by a specific family member. There was no documentation that medication was administered or blood pressure checks were performed. On 10/31/23 in the morning, a Medication Technician indicated they do not check blood pressure for R5 or administer R5 Carvedilol or Clonidine. The Medication Technician revealed they did not monitor if R5 received the medications or if the blood pressures were checked and if the Clonidine and Carvedilol were kept in R5's room. On 10/31/23 in the morning, R5 revealed they had not had their blood pressure checked in a long time and was unsure if they were receiving blood pressure medications. There was no Clonidine present in the room of R5. On 10/31/23 in the morning, a Medication Technician confirmed there was no Clonidine present in the room of R5 and was not sure if the family members had the medication or if it was being administered according to physician orders. On 10/31/23 in the morning, an interview was conducted with the family member specified in the physician order of R5. The family member indicated they had not given Clonidine or Carvedilol in a long time to R5 and had not been checking R5's blood pressure because they thought the order was discontinued. The family member revealed the facility did not inform them the medications were still active. Review of Medication Review sheet for R5, dated 08/08/23, documented the orders for Clonidine and Carvedilol were still active.			

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	On 10/31/23 in the morning, the Wellness Director confirmed orders for R5 including Clonidine and Carvedilol were still active and was unsure if the blood pressure checks and medication were being administered. Severity: 2 Scope: 1			
1540 SS= E	Cultural Competency Training - R016-20 Section 14.1 1. Pursuant to subsection 1 of NRS 449.103, within 30 business days after the course or program is assigned a course number by the Division pursuant to section 18 of this regulation or within 30 business days of any agent or employee being contracted or hired, whichever is later, and at least once each year thereafter, a facility shall conduct training relating specifically to cultural competency for any agent or employee of the facility who provides care to a patient or resident of the facility so that the agent or employee may: (a) More effectively treat patients or care for residents, as applicable; and (b) Better understand patients or residents who have different cultural backgrounds, including, without limitation, patients or residents who fall within one or more of the categories in paragraphs (a) to (f), inclusive, of subsection 1 of NRS 449.103. Inspector Comments: Based on interview and record review, the facility failed to ensure Cultural Competency training was completed within 30 days of hire for 3 of 10 employees (Employee #1, Employee #2 and Employee #5). Findings include: Employee # (E1) E1 was hired on 11/29/22 as a Medication Technician. A review of employee records did not reveal documentation of initial Cultural Competency training for E1. Employee #2 (E2) E2 was hired on 03/28/23 as a Caregiver. A review of employee records did not reveal documentation of initial Cultural Competency training for E2. Employee #5 (E5) E5 was hired on 05/02/23 as a Medication Technician. A review of employee records did not reveal documentation of initial Cultural	1540	1. Employee #1 completed Nevada Cultural Competency Training on 11/11/2023. Employee #2 completed Nevada Cultural Competency Training on 11/07/2023. Employee #5 completed Nevada Cultural Competency Training on 11/12/2023. 2. Administrator will review and update Employee File Tracker on a monthly basis to ensure that all employees are current with Nevada Cultural Competency Training within 30 days of hire. Administrator will ensure that current Nevada Cultural Competency certificates are placed in employee file upon completion and Employee File Tracker is updated to reflect completion with new expiration date. 3. Administrator will review Employee File Tracker on a monthly basis. 4. Administrator will monitor for compliance. 5. 11/12/2023	11/12/2023

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**10/31/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER SKY AT DEER SPRINGS ASSISTED LIVING	**6741 N DECATUR BLVD BLDG #3, LAS VEGAS, NEVADA ,89130**

(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
	Competency training for E5. On 10/31/23 in the morning, the Executive Director confirmed E1, E2 and E5's employee records lacked documented evidence Cultural Competency training was completed within 30 days of hire. Severity: 2 Scope: 2			