

Division of Public and Behavioral Health

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>6013</b>                                  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     | (X3) DATE SURVEY<br>COMPLETED<br><br><b>05/21/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SILVER SKY AT DEER SPRINGS ASSISTED LIVING</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br><b>6741 N DECATUR BLVD BLDG #3, LAS VEGAS, NEVADA ,89130</b> |                                                                                                                          |                                                        |
| (X4)<br>ID<br>PREFIX<br>TAG<br><br><b>0000</b>                                        | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY<br>OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG<br><br><b>0000</b>                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE                             |
|                                                                                       | <p>Initial Comments</p> <p>Inspector Comments: This Statement of Deficiencies was generated as a result of a State licensure survey conducted in your facility on 05/07/24 through 05/21/24, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facilities for Groups. The facility was licensed for 96 Residential Facility for Group beds for elderly and disabled persons and/or requiring assisted living services, 82 Category-I and 14 Category-II residents. The facility has applied for a two-bed increase and was approved to add two group beds which provide services for elderly and disabled persons and/or persons requiring assisted living services, for a total of 84 Category-I beds and 14 Category II beds bringing the total beds to 98. 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. There were no regulatory deficiencies identified. No further action is necessary. Please retain a copy for your records.</p> |                                                                                                           |                                                                                                                          |                                                        |

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: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_  
REPRESENTATIVE'S SIGNATURE