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 _____	**10/15/2025**

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**

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of an annual State Licensure and Complaint Investigation survey completed at your facility on 10/15/25, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for 98 Residential Facility for Group beds (84 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 84. Nineteen resident files and eight employee files were reviewed. The facility received a grade of A. There was one complaint investigated: Unsubstantiated: Complaint #NV00074845 could not be substantiated. No regulatory deficiencies could be identified. The investigation of complaints included: Observation of meal service to residents in rooms, residents were free from abuse, caregivers available to residents and staff making rounds on all levels of the facility. Interviews were conducted with residents and the Wellness Director. Document Review for resident of concern and incident reports. 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 investigations, actions or other claims of relief that may be available to any part under applicable federal, state, or local law. The following regulatory deficiencies were identified.	0000		
0255 SS= E	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.	0255	Y 255 – Plan of Correction: 1) How you will correct the specific finding(s) in the Statement of Deficiencies (must Address): Expired cartons of Buttermilk were discarded the same day of the inspection on 10-15-2025 and Scoops were removed	10/31/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: STEVEN STARKEY Title: Administrator Date: 10/31/2025

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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	Inspector Comments: Based on observation on 10/15/2025, 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, an open carton of buttermilk was expired on 07/06/25 and four cartons of buttermilk were expired on 09/27/25. 2. Major Violations: a. A scoop was stored in a container of lemonade powder with the handle touching the product. Severity: 2 Scope: 2		from Lemonade containers. 2) What measures or Systematic change (s) will be put in place to ensure the deficient practice does not recur (Must Address): Training/ Inservice of all kitchen staff was completed on 10-31-2025 for proper inspection of expiration dates and removing any items that are close to expiration. Inservice also included instruction on the practice of removing scoops from lemonade containers. 3) How the corrective action(s) will be monitored to ensure the deficit practice will not recur (Must Address): Staff and Manager to monitor daily 4) The title of person (position) responsible for ensuring the plan of correction is implemented (DO NOT INCLUDE PERSONAL NAMES,JUST USE THE TITLE or POSITION) (Must Address); Director of Culinary Services and Administrator 5) The Date the corrective action will be completed(Must Include); 10-31-2025 6) You must attach all supporting documents into the system (must Include): Attached to POC email is signed copy of the Kitchen Inservice from 10-31-2025. 7) How will you identify and correct other area shaving potential to affected by the same deficient practices. (if applicable). Review will include expiration dates on all open and closed containers.	
0874 SS= E	Medication Administration-Report Received - NAC 449.2742 and R043-22 - Administration of medication:	0874	Y 874 – Plan of Correction	10/31/2025

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	Responsibilities of administrator, caregiver and employees of facility. 2. Within 72 hours after the administrator of the facility receives a report submitted pursuant to paragraph (a) of subsection 1, a member of the staff of the facility shall notify the resident's physician, physician assistant or advanced practice registered nurse of any concerns noted by the person who submitted the report. The report must be reviewed and initialed by the administrator. Inspector Comments: Based on record review and interview, the facility failed to ensure the Administrator reviewed and initialed six-month medication reviews for 8 of 19 sampled residents (Residents #1, #3, #4, #5, #6, #7, #14, #15). Finding include: Resident #1 (R1) R1 was admitted on 01/21/21 with diagnoses including dementia and hypertension. R1's file documented a medication review form dated 09/19/25. R1's medication review lacked evidence of the Administrators review and initials. Resident #3 (R3) R3 was admitted on 04/12/19 with diagnoses including bipolar and hypertension. R3's file documented a medication review form dated 06/09/25. R3's medication review lacked evidence of the Administrators review and initials. Resident #4 (R4) R4 was admitted on 05/26/16 with diagnoses including peripheral vascular disease and heart disease. R4's file documented a medication review form dated 06/09/25. R4's medication review lacked evidence of the Administrators review and initials. Resident #5 (R5) R5 was admitted on 02/08/24 with diagnoses including Parkinson's Disease and diabetes. R5's file documented a medication review form dated 06/09/25. R5's medication review lacked evidence of the Administrators review and initials. Resident #6 (R6) R6 was admitted on 04/21/18 with diagnoses including dementia and hypertension. R6's file documented a medication review form dated 06/09/25. R6's medication review lacked evidence of		1) How you will correct the specific finding(s) in the Statement of Deficiencies (must Address): Completed the signing of all the6-month Pharmacy Reviews for Residents #1, #3, #4, #5, #6, #7, #14 and #15 by10-22-2025. 2) What measures or Systematic change (s) will be put in place to ensure the deficient practice does not recur (Must Address): RCC– Residential Care Coordinator will bring all Pharmacy Reviews to Administrator when received to be signed. 3) How the corrective action(s) will be monitored to ensure the deficit practice will not recur (Must Address): Reviews and Signatures by Administrator will be completed as soon as possible after receipt Pharmacy Reviews by the RCC. 4) The title of person (position) responsible for ensuring the plan of correction is implemented (DO NOT INCLUDE PERSONAL NAMES, JUST USE THE TITLE or POSITION) (Must Address); Administrator, Nurse and RCC. 5) The Date the corrective action will be completed (Must Include); 10-22-2025 6) You must attach all supporting documents into the system (must Include): Attached to the POC Email are all the signed Pharmacy reviews for Residents #1, #3, #4, #5, #6, #7, #14 and #15 7) How will you identify and correct other area shaving potential to affected by the same deficient practices. (if applicable).To be reviewed Monthly by Administrator	

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	the Administrators review and initials. Resident #7 (R7) R7 was admitted on 09/30/24 with diagnoses including anemia and arteriosclerosis. R7's file documented a medication review form dated 06/09/25. R7's medication review lacked evidence of the Administrators review and initials. Resident #14 (R14) R14 was admitted on 09/04/25 with diagnoses of chronic obstructive pulmonary disease and hypertensive heart disease. R14's file documented a medication review form dated 09/02/25. R14's medication review lacked evidence of the Administrators review and initials. Resident #15 (R15) R15 was admitted on 06/23/22 with a diagnosis of malignant neoplasm of the brain. R15's file documented a medication review form dated 06/09/25. R15's medication review lacked documented evidence of the Administrator's review and initials. On 10/15/25 in the afternoon, the Administrator acknowledged the missing Administrator initials on the medication reviews for R1, R3, R4, R5, R6, R7, R14, and R15. Severity: 2 Scope: 2			
1825 SS= E	Designation/Training persons for IC Program - NAC 449.0109 Designation and training of person responsible for infection control. 3. The program to prevent and control infections within the facility for the dependent developed pursuant to paragraph (a) of subsection 1 must provide for the designation of: (a) A primary person who is responsible for infection control; and (b) A secondary person who is responsible for infection control when the primary person is absent to ensure that someone is responsible for infection control at all times. 4. The persons designated pursuant to subsection 3 as responsible for infection control shall complete not less than 15 hours of training concerning the control and prevention of infections provided by the Association for Professionals in Infection Control and Epidemiology, Inc., the Centers for Disease Control and Prevention of the United States Department of Health and	1825	Y 1825 – Plan of Correction 1) How you will correct the specific finding (s)in the Statement of Deficiencies (must Address): Employee #6 completed the 15 Hours of Infection Control Training on 10-31 -25 2) What measures or Systematic change(s) will be put in place to ensure the deficient practice does not recur (Must Address): Placed Training Expirations in Calendar to ensure training is completed yearly 3) How the corrective action(s) will be monitored to ensure the deficit practice will not recur (Must Address): Training Due dates added to calendar 4) The title of person (position) responsible for ensuring the plan of correction is	10/31/2025

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	Human Services, the World Health Organization or the Society for Healthcare Epidemiology of America, or a successor in interest to any of those organizations, not later than 3 months after being designated and annually thereafter. 5. Training completed pursuant to subsection 4 may be in any format, including, without limitation, an online course provided for compensation or free of charge. A certificate of completion for the training must be maintained in the personnel file of each person designated pursuant to subsection 3 for 3 years immediately following the completion of the training. Inspector Comments: Based on record review and interview, the facility failed to ensure the primary infection control staff member completed 15 hours of infection control training annually (Employee #6). Findings include: Employee #6 (E6) was hired on 02/14/24 as the Administrator. E6 was identified as the primary infection control manager for the facility. E6's file revealed 15 hours of infection control training was last completed on 06/05/24. On 10/15/25 in the morning, the Administrator confirmed 15 hours of infection control training had not been completed by the primary infection control manager since 06/05/24. Severity: 2 Scope: 2		implemented (DO NOT INCLUDE PERSONALNAMES, JUST USE THE TITLE or POSITION) (Must Address); Administrator 5) The Date the corrective action will be completed (Must Include); 10-31-2025 6) You must attach all supporting documents into the system (must Include): Have attached to email for POC the Completed Training Certificate for Employee #6. 7) How will you identify and correct other areas having potential to affected by the same deficient practices. (if applicable). Monitor calendar monthly to review expiring training due.	