Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	6013	A. BUILDING _____ B. WING _____	12/09/2025

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

(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 0000- No 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. The RFG was found to be in substantial compliance. No regulatory deficiencies were identified. No further action is necessary. Inspector Comments: This Statement of Deficiencies was generated as a result of a complaint investigation completed at your facility on 12/09/25. The census at the time of the survey was 79. The sample size was five. The facility received a grade of A. There was one complaint, and one facility reported incident (FRI) investigated. Unsubstantiated. 1. FRI #12497 could not be substantiated. No deficiencies could be identified.	RFG 0000- No Deficiencies		

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 REPRESENTATIVE'S SIGNATURE Name: Title: Date:

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	2. Complaint #12524 could not be substantiated. No deficiencies could be identified. The investigation of the complaint and FRI included: Observation of appropriate staff/resident interactions, residents freely coming and leaving the facility, residents receiving assistance and residents' hygiene appropriate. Interviews were conducted with the Director of Wellness, Caregivers, Medication Technicians, the Dining Director, the Administrator and residents. Clinical record review of five residents' records, which included the residents of concern. Document review of facility policies and procedures, facility menu, resident council minutes and facility incident reports.			