

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

PRINTED: 6/15/2026
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/18/2023
NAME OF PROVIDER OR SUPPLIER STARLIGHT GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2301 EAST 9TH ST., RENO, NEVADA ,89512	
(X4) ID PREFIX TAG 0000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG 0000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a complaint investigation and State Licensure Address Verification Survey conducted at your facility on 5/16/23 and concluded on 05/18/23. This State investigation was conducted by the Division of Public and Behavioral Health in accordance with Nevada Administrative Code, Chapter 449, Residential Facility for Groups. The census at the time of investigation was zero. Complaint #NV00068463 with the allegation a Guardian of a resident was not notified nor approved for a move to another facility could not be substantiated due to a lack of evidence. The investigation into the allegation included: Observation of the facility. An interview was conducted with the Administrator. Document review included notification to residents, Fire Marshall notifications, and landlord notification for the location specified. The survey team arrived at the Residential Facility for Groups and found the location was vacant. A phone call was placed to the Administrator of the facility who verbalized the facility was being closed due to major renovations. All residents were notified and moved to another Resident Facility for Groups. As a result, the facility will no longer be operating at this location. 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 for relief that may be available to any party under applicable federal, state, or local laws. No regulatory deficiencies were identified. No further action is necessary. Please retain a copy of this report for your records.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER Name:
REPRESENTATIVE'S SIGNATURE

Title:

Date:

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.