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 |
|---|---|---|---|
| | 10550 | A. BUILDING _____ B. WING _____ | 03/29/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUMMERSET RENO ASSISTED LIVING | 6215 SHARLANDS AVE, RENO, NEVADA ,89523 |

| (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<br><br>Inspector Comments: This Statement of Deficiencies was generated as a result of an initial State Licensure survey conducted in your facility on 03/29/23, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility had applied for one hundred ten (110) residential facility for groups beds which provides assisted living services for elderly or disabled persons and/or persons with chronic illness and/or persons with mental illness and/or persons with Alzheimer's disease, eighty Category I residents, twenty Category II non-Alzheimer's residents and ten Category II Alzheimer's residents. The license is granted for one hundred ten (110) residential facility for groups beds which provides assisted living services for elderly or disabled persons and/or persons with chronic illness and/or persons with mental illness, eighty Category I residents, and thirty Category II non-Alzheimer's residents. The census at the time of the survey was zero. One mock resident record was reviewed and one employee personnel file was reviewed. 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 necessary. Please retain a copy for your records. | 0000 | | |

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: