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 _____	**04/09/2024**

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 Inspector Comments: This Statement of Deficiencies was generated as a result of a State Licensure complaint investigation conducted at your facility on 03/09/24, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for 110 Residential Facility for Group beds for elderly and disabled persons, and/or mental illness and/or providing assisted living services, 80 Category I residents and 30 Category II residents. The census at the time of the survey was 73. Two resident files were reviewed. One complaint was investigated. Complaint #NV00070510 with the following allegations could not be substantiated due to lack of evidence. Allegation #1: The facility failed to provide adequate nutrition to residents. Allegation #2: The facility does not have properly running cold water. Allegation #3: The facilities staff failed to answer resident call lights within a timely manner. Allegation #4: The facility does not have adequate staffing to resident ratio. The investigation into the allegations included: Observations of resident rooms and bathrooms, staff and resident interactions, dining staff and resident interactions, kitchen and dining room operations, food storage, and staff response to resident call lights. Interviews with two residents, the Executive Director, a cook, and the Dietary Director. Review of the facility's Residence and Care Agreement, and the facilities weekly dining menu. 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. No regulatory deficiencies were identified. No further action necessary. Please retain a copy for your records.	0000		

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