

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10953	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/24/2023
NAME OF PROVIDER OR SUPPLIER SUMMERSET RENO MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 6205 SHARLANDS AVE, RENO, NEVADA ,89523		
(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 an initial State Licensure survey initiated in your facility on 10/23/23 and concluded on 10/24/23, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility had applied for one hundred three (103) 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, fifty-five (55) Category II Alzheimer's residents and forty-eight (48) 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.			

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 Name: Title: Date:
REPRESENTATIVE'S SIGNATURE