

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 11/15/2022
NAME OF PROVIDER OR SUPPLIER ATRIA SUMMIT RIDGE			STREET ADDRESS, CITY, STATE, ZIP CODE 4880 SUMMIT RIDGE DRIVE, 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 a complaint investigation conducted in your facility on 11/15/22. This State Licensure Survey was conducted in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for 85 Residential Facility for Group beds for elderly and disabled persons, and/or chronic illness, and/or mental illness and/or providing assisted living services, 63 Category I residents and 22 Category II residents. The census at the time of the survey was 71. The sample size was five - three current residents and two discharged residents. The facility received a grade A. There were two complaints investigated. Complaint #NV00065561 with the following allegation could not be substantiated. Allegation #1: The facility would not provide a copy of an incident report to a resident's family after the resident fell. The investigation into the allegation included the following: Interviews with the Executive Director. Record review including activities of daily living, incident reports, and resident communication. Document review including Resident Agreement, which included Authorization for Release of Information. Facility policy review including Fall Assessment Policy. Complaint #NV00065648 with the following allegation could not be substantiated. Allegation #1: The facility did not perform a PCR COVID test on a resident with COVID-19 symptoms. The investigation into the allegation included the following: Interviews with the Executive Director. Record review including activities of daily living, incident reports, and resident communication. Facility policy review including COVID-19 Protocol. 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			

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.

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	other claims for relief that may be available to any party under applicable federal, state or local laws. There were no regulatory deficiencies identified.						