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 _____	**02/27/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SEASONS OF RENO, ASSISTED LIVING & MEMORY CARE	**5165 SUMMIT RIDGE COURT, RENO, NEVADA ,89523-9092**

(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 complaint investigation completed in your facility on 02/27/24, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facilities for Groups. The census at the time of the survey was 97. The facility was licensed for 120 total Residential Facility for Group beds, with 90 beds for elderly and disabled persons and/or provides assisted living services and 30 beds for care to persons with Alzheimer's disease, Category II residents. The sample size was three. The facility received a grade of A. One complaint was investigated. Complaint #NV00070095 with the following allegations could not be substantiated due to lack of evidence: Allegation #1: The facility failed to implement an infection control policy during a potential COVID-19 outbreak. Allegation #2: The facility failed to implement proper incontinent care for a resident. Allegation #3: The facility failed to implement proper precautions regarding safety/falls for a resident. Allegation #4: A resident was left with a wet brief for an extended period of time. Allegation #5: The facility failed to use pressure sore precautions for a resident. Allegation #6: The facility failed to properly train staff on resident safety and care. Investigation into the allegations included: Observations of staff interacting with residents, staff responding to call lights, resident rooms and bathrooms, and infection control supply storage. Interviews were conducted with one resident, a Caregiver, the Health and Wellness Director, and the Executive Director. Clinical record review included three resident records, including the resident of concern, physician orders, History and Physicals, Activities of Daily Living assessments, and Standard Physician Placement Determinations. Document review included the Infection Control policy, training	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.

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	requirements for staff, Resident Safety and Fall Policy, Resident Quality of Care Policy, staffing schedules, and Resident Incontinent Care policy. 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.			