

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 A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/04/2024
NAME OF PROVIDER OR SUPPLIER THE SEASONS OF RENO, ASSISTED LIVING & MEMORY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 5165 SUMMIT RIDGE COURT, RENO, NEVADA ,89523-9092	
(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 completed in your facility on 04/04/2024, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facilities for Groups. The census at the time of the survey was 98. 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 five. The facility received a grade of A. One complaint was investigated. Complaint #NV00070721 with the following allegations could not be substantiated due to a lack of evidence: - Allegation #1: A resident was left with a soiled brief for an extended period of time and was not cleaned properly after incontinence. -Allegation #2: A resident's room was shown to a visitor without permission. Observations of staff to resident interactions in the common area, dining room, and during activities. Interviews were conducted with the two residents, a Care Partner, the Health and Wellness Coordinator, the Health and Wellness Director, and the Administrator. Resident record review of five residents, including the resident of concern, to include physician orders, service plans, progress notes, communication documents, medication administration records, standard assessments, discharge documents, and history and physicals. Document review included staffing lists/schedules, Resident Rights, Resident Handbook, Abuse and Neglect Reporting Guidelines, Admission Contracts/Forms, and an Evaluation 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			

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.

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 04/04/2024	
NAME OF PROVIDER OR SUPPLIER THE SEASONS OF RENO, ASSISTED LIVING & MEMORY CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 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	
	relief that may be available to any party under applicable federal, state or local laws. No regulatory deficiencies were identified. No further action is required. Please retain a copy for your records.						