

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 6/15/2026  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                       |                                                                                                                          |                                                        |
|--------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     | (X3) DATE SURVEY<br>COMPLETED<br><br><b>11/13/2020</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SOUTH MEADOWS RESIDENTIAL CARE HOME</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br><b>13495 STONEY BROOK DR, RENO, NEVADA ,89511</b>                           |                                                        |
| (X4)<br>ID<br>PREFIX<br>TAG<br><br><b>0000</b>                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY<br>OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG<br><br><b>0000</b>                | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE                             |
|                                                                                | <p>Initial Comments</p> <p>Inspector Comments: This Statement of Deficiencies was generated as a result of a complaint investigation conducted at your facility on 11/13/20, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The census at the time of the survey was seven. Eight resident records, including one closed record were reviewed. There was one complaint investigated. Complaint# NV00062214 with the following allegations could not be substantiated: Allegation #1: a resident's family was not allowed to visit the resident while on hospice could not be substantiated based on review of the facility's COVID-19 policy related to visitation and documentation of the resident of concerns family having violated the facility policy of mask wearing and social distancing during a prior visit with the resident. Allegation #2: a resident had an untreated pressure sore could not be substantiated based on a lack of documented evidence in the resident of concerns record of a pressure sore or wound. The investigation into the allegations included: Observations of residents in their rooms and in the common areas. Interviews were conducted with the Owner. Reviewed eight resident records including the resident of concern, visitor log, documented communication with the resident of concerns family, and the facility policy, "Infection Control-COVID-19: Policy and Procedure Manual," effective date 09/19/20. 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 is required. Please retain a copy for your records.</p> |                                                       |                                                                                                                          |                                                        |

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.