

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

PRINTED: 6/8/2026
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 09/30/2021	
NAME OF PROVIDER OR SUPPLIER A SUMMERDALE HOMES AT RIATA, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 14315 RIATA CIRCLE, RENO, NEVADA ,89521			
(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 initiated at your facility on 09/07/21 and completed on 09/30/21, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for eight Residential Facility for Group beds for elderly and disabled persons, Category II residents. The census at the time of the survey was 8. The sample size was five. There was one complaint investigated. Complaint #NV00064751 with the following allegation was substantiated. Allegation #1: The resident was neglected by the caregiver by leaving the resident on the floor while the caregiver called the Administrator for assistance with getting the resident off the floor. The Caregiver left the resident on the floor for an extend period (See Tag Y050, and Y085). 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 other claims for relief that may be available to any party under applicable federal, state or local laws. The following regulatory deficiencies were identified:		0000				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER Name: EUGENE GASATAYA Title: Administrator
REPRESENTATIVE'S SIGNATURE

Date: 11/07/2021

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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0050 SS= D	Administrator's Responsibilities - Oversight - NAC 449.194 Responsibilities of administrator. (NRS 449.0302) The administrator of a residential facility shall: 1. Provide oversight and direction for the members of the staff of the facility as necessary to ensure that residents receive needed services and protective supervision and that the facility is in compliance with the requirements of NAC 449.156 to 449.27706, inclusive, and chapter 449 of NRS. Inspector Comments: Based on observation, record review, and interview, the Administrator failed to provide oversight and direction to staff to ensure the facility complied with certain requirements of Nevada Administrative Code 449.156 to 449.27706, inclusive, and Nevada Revised Statutes Chapter 449. Findings include: Please see Tags Y0085. Severity: 2 Scope: 1	0050			11/07/2021		
0085 SS= D	Staffing - Cg on Duty All Times - NAC 449.199 Staffing requirements 1. The administrator of a residential facility shall ensure that a sufficient number of caregivers are present at the facility to conduct activities and provide care and protective supervision for the residents. There must be at least one caregiver on the premises of the facility if one or more residents are present at the facility. Inspector Comments: Based on observation, record review and interview, the Administrator failed to ensure a sufficient number of caregivers were on duty to assist a resident in a timely manner after a fall for 1 of 8 residents (Resident #2). Findings include: On 09/07/21 in the morning, one Caregiver was observed providing care for all the residents. There were no other Caregivers on the premises upon arrival to the facility. The Caregiver is scheduled to work the morning and night shift, all 24 hours of each day. The Caregiver was unable to provide care and	0085			11/07/2021		

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	protective supervision for all the residents. Resident #2 Resident #2 was admitted to the facility on 02/28/20 with a diagnosis of cancer, dyslipidemia, and stroke involving left face and left upper extremity. Resident #2's record documented evidence of a physician physical assessment completed on 02/28/20 and 05/13/21, which documented resident had frequent falls. On 05/13/21, the physician documented resident was subject to frequent falls and needed assist with basic Activities of Daily Living (ADL). Resident #2's ADL log dated 02/27/21 and 05/13/21, documented the resident required assistance with bed mobility/transfers. On 09/07/21 at 11:02 AM, the Caregiver explained Resident #2 had fallen in their room and off the bed on 08/30/21. The Caregiver acknowledged leaving Resident #2 on the floor while the Caregiver called the Administrator for assistance getting Resident #2 off the floor. The Caregiver verbalized being unable to assist Resident #2 alone. During this time, Resident #2 was on the floor for 20 to 30 minutes while waiting for the Administrator to arrive. The Caregiver confirmed proper supervision and follow-up assistance was not provided for a resident who had fallen. The Caregiver verbalized every time Resident #2 fell off the bed, Resident #2 refused to go to the hospital for care. On 09/30/21 at 8:26 AM, the Administrator explained Resident #2 frequently fell from the bed and confirmed Resident #2 has multiple falls off the bed. The Administrator verbalized the facility protocol when a resident had fallen, the Caregiver was instructed to call the Administrator to come to the facility and assist with the resident. During this time, the resident could be on the floor for 30 to 45 minutes waiting for the Administrator to arrive. Severity: 2 Scope: 1 Complaint #NV00064751						