

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 10/19/2021
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 10/19/21 and completed on 10/28/21, 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 4. The sample size was one. There was one complaint investigated. Complaint #NV00064989 with the following allegations was substantiated. Allegation #1: Resident was hiding the medication in the bedroom without the Caregiver knowledge (See Tag Y876). Allegation #2: The facility refused to provide a 30-day eviction notice to the resident and to the guardian could not be substantiated because interview with the Administrator and review of Resident Admission and Agreement Record lacked sufficient evidence of a deficient practice. 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		
0515 SS= D	Supervision and Treatment of Residents - NAC 449.259 Supervision and treatment of residents generally. (NRS 449.0302) 1. A residential facility shall: (a) Provide each resident with protective supervision as necessary; (b) Inform all caregivers of the required supervision; Inspector Comments: Based on record review, interview and document review, the facility failed to provide protective supervision for 1 of 4 residents (Resident #1) resulting in an intentional medication	0515	0515 NAC 449.259 Supervision and treatment of resident generally Facility is in compliance. Resident #1 was discharged upon the resident's disclosure of a suicide attempt where the resident had accumulated 10 Hydrocodone pills for several months and took them all at once on 09/23/2021. The facility is not equipped to monitor a very alert resident who is able to take meds in front of the caregiver and still manage to hide meds in the mouth or by the sleight of hand. According to	09/23/2021

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

Date: 12/28/2021

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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	overdose. Findings include: Resident #1 Resident #1 was admitted to the facility on 02/20/20 with a diagnosis of osteoarthritis of the site disorder, hyperlipidemia, and neuropathy. Resident #1's record documented evidence of a physician physical assessment completed on 05/21/21, which documented resident past medical history depression and needs assists with Activities of Daily Living (ADL). The facility's Ultimate User Agreement, dated 02/18/20, documented the resident authorized the Caregiver of the facility to possess and administer medications to the resident. Activities of Daily Living Assessment (ADL) dated 09/01/21 - 09/12/21, documented the resident was cognitive deficient with behavior issues. On 10/19/21 at 10:09 AM, the Caregiver explained Resident #1 had intentionally ingested medications and was transported to the hospital on 09/23/21. On 10/19/21 at 1:33 PM, the Administrator explained the facility was not aware Resident #1 had been hiding and saving their medications. The Administrator verbalized Resident #1 was mentally alert. The Administrator verbalized as soon he was made aware of the incident with Resident #1, the Administrator immediately contacted Emergency Medical Services for transport to the hospital. The Administrator verbalized the facility was now having every resident open their mouth and tongue to make sure they had swallowed their medication. Complaint #NV00064989 Severity: 2 Scope: 1		Resident #1, about 10 pain medicine was accumulated in a period of several months with the purpose of committing suicide. Resident #1 disclosed the suicide attempt to a family member who alerted the administrator immediately. Administrator instructed the caregiver to call 911 asap. When the administrator arrived in the facility, Resident # 1 was not cooperating and refused to disclose where the meds were hidden. Administrator has taken extreme measures to the dismay of remaining residents and have caregivers see meds taken by each resident with the caregiver administering meds with a spoon to the residents' mouth. Caregivers were instructed to have residents to open their mouth to check under tongue to double check that all meds are swallowed with no possibility of any meds being reused per administration of medication. Residents are instructed again to drink fluids even though remaining residents have completely swallowed their meds for the extreme measure that medications are never to be reused for a latter time.				

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0945 SS= D	Maintenance and Contents of Separate File - NAC 449.2749 Maintenance and contents of separate file for each resident; confidentiality of information. (NRS 449.0302) 3. Except as otherwise provided in this subsection, a resident's file must be kept confidential. A resident's file must be made available upon request at any time to an employee of the Bureau who is acting in his or her capacity as an employee of the Bureau. Inspector Comments: Based on observation, and interview the Administrator failed to ensure resident medical records were available at the facility upon request, during a complaint investigation Findings include: On 10/19/21 at 10:04 AM, upon entry the facility, the Caregiver verbalized there were currently four residents living in the facility. On 10/19/21 at 10:14 AM, during the residents' medical record review, Resident #1's record was not on site and available for review by the State licensing agency. On 10/19/21 at 10:14 AM, the Caregiver verbalized Resident #1 was no longer in the facility and the resident's medical record was with the Administrator. The Caregiver confirmed Resident #1's medical record was not on site and available for review. The Administrator was not at the facility. On 10/19/21 at 1:33 PM, the Administrator verbalized Resident #1's medical record was onsite. The Administrator explained the Caregiver did not know where the medical record was for Resident #1 because the Administrator was the only one who knew where the discharged resident records were in the facility. On 10/19/21 at 1:33 PM, a request for Resident #1's documents was requested via email to the Administrator. Severity: 2 Scope: 1	0945	0945 Maintenance and Contents of Separate Files Facility is in compliance. Caregiver was reminded that HCQC officials can see resident files at all times and that HCQC employees have full authority over resident files unlike state ombudsman, state social worker, and state Medicaid worker who have limited authority to access all resident files. Caregiver was reminded where the files of former residents are kept.		10/19/2021		