

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

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

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| 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>12/18/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>APRIL'S VILLA</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br><b>10450 ARBOR WAY, RENO, NEVADA ,89521</b>                                 |                                                        |
| (X4)<br>ID<br>PREFIX<br>TAG<br><br>0000                  | 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>0000                       | 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 initiated at your facility on 12/18/19. This State investigation was conducted by the Division of Public and Behavioral Health in accordance with NAC 449, Residential Facility for Groups. The census at the time of investigation was six. The sample size was seven. Complaint #NV00059637 with the following allegation could not be substantiated. Allegation #1: Facility manager was administering Ativan to a resident without a physician order. The investigation into the allegations included: Observation of residents and a tour of the facility. Interviews were conducted with the Administrator and a Caregiver. Review of seven resident files including the resident of concern. Document review included Medication Administration Records, Physician Orders, History and Physicals, hospital records, Activities of Daily Living, medication reviews, Medication Authorization forms, Admission records, Discharge records, Medication removal and destruction logs and Incident Reports. 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. No regulatory deficiencies were identified. No further action is necessary. Please retain a copy of this report 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.