

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>9659</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/11/2022</b>	
NAME OF PROVIDER OR SUPPLIER  <b>ALTA SKILLED NURSING AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>555 HAMMILL LANE, RENO, NEVADA ,89511</b>		
(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	<p>Initial Comments -</p> <p>Inspector Comments: This Statement of Deficiencies was generated as a result of a state licensure construction standards bed increase survey conducted at your facility on 09/10/21, with supplemental documentation provided on 01/11/22. The survey was conducted in accordance with Nevada Administrative Code (NAC) 449, Facilities for Skilled Nursing. The following areas were renovated: Resident Room #317 and #318 were private (single occupancy) rooms and were renovated to shared (double occupancy) rooms. The facility applied for two additional skilled nursing beds. This application was approved and the facility is licensed for 180 skilled nursing beds. The facility's construction type per NFPA 220 is Type V (111) and the facility is fully equipped with an automatic fire sprinkler system. The facility is a single story building. The code editions for this project include the 2018 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 2018 Edition of the Guidelines for the Design and Construction of Residential Health, Care, and Support Facilities, "The Facility Guidelines Institute (FGI)." 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. The facility was found to be in substantial compliance with the regulations. No further action is necessary concerning this Statement of Deficiencies/Plan of Correction (SOD/POC). Please retain this copy of the SOD/POC for your records.</p>	0000		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER Name: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_  
REPRESENTATIVE'S SIGNATURE