STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11048	A. BUILDING _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER AT RANCHARRAH	5255 KIETZKE LANE, RENO, NEVADA ,89511

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted at your facility on 08/29/2024. This State Licensure survey was conducted by the Division of Public and Behavioral Health in accordance with NAC 449, Residential Facility for Groups. The facility was licensed for 142 residential facility for group beds with 104 beds for elderly and/or disabled persons and provide assisted living services, Category II residents; and 38 beds for persons with Alzheimer's disease, Category II residents. The census at the time of the survey was 121. 25 resident records and 25 employee records were reviewed. The facility received a grade of D. NAC 449.27706 Resurvey: Application and fee; failure to comply. 2. If the Bureau issues a placard to a residential facility that includes a grade of "C" or "D," the administrator must submit an application to the Bureau for a resurvey of the facility not later than 30 days after the facility receives the placard. The fee for an application for a resurvey is $600 and must accompany the application. 3. The Bureau may revoke the license of a residential facility that is required to submit an application for a resurvey pursuant to subsection 2 if the facility fails to submit the application in accordance with the provisions of that subsection. 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		
0065 SS= D	Qualifications of Caregivers-Age-Eng-Training - NAC 449.196 and LCB File No. R043-22 Qualifications and training of caregivers. (NRS 449.0302) 1. A caregiver of a residential facility must: (a) Be at least 18 years of age; (b) Be responsible and mature and have the personal qualities which will enable him or her to understand the problems of elderly persons and	0065	On September 6, 2024, we did a complete audit ofour employee files to confirm each had the required training. We pulled employees #3, # 17, 22 and #24 inorder to allow them to complete	09/06/2024

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	persons with disabilities; (c) Understand the provisions of NAC 449.156 to 449.27706, inclusive, and sections 2 to 16 inclusive of this regulation and sign a statement that he or she has read those provisions; (d) Demonstrate the ability to read, write, speak and understand the English language; (e) Possess the appropriate knowledge, skills and abilities to meet the needs of the residents of the facility; and (f) Not later than 60 days after commencing employment with the residential facility, receive not less than 4 hours of a combination of tier 1 and tier 2 training related to care for the residents of the facility; and (g) Receive annually not less than 8 hours of training related to providing for the needs of the residents of a residential facility. Such training must include, without limitation, at least 2 hours of tier 2 training. Inspector Comments: Based on record review and interview, the facility failed to provide documented evidence 4 of 25 sampled employees working at the facility one year or more completed at least eight hours of annual caregiver training (Employee #3, #17, #22, and #24). Findings include: On 08/29/2024 at 10:21 AM, the Business Office Director was provided the Personnel Checklist to complete for 25 sampled employees. The Business Office Director returned the partially completed checklist on 08/29/2024, and provided additional documentation related to personnel files for sampled employees on 09/02/2024 via electronic mail, with the following information: Employee #3 Employee #3 was hired by the facility as the Health Services Director with a start date of 04/14/2022. Employee #3's personnel file lacked documented evidence of eight hours of annual caregiver training. Employee #17 Employee #17 was hired by the facility as an Assisted Living Care Partner with a start date of 08/26/2022. Employee #17's personnel file lacked documented evidence of eight hours of annual caregiver training. Employee #22 Employee #22 was hired by the facility as an Assisted Living Medication Technician (AL Med Tech) with a start date of 07/27/2021. Employee #22's personnel		the 8 hour of annual caregiving training. We will monitor compliance on an ongoing basis. More specifically, the Business Office Director and or designee will complete a fullRelias audit within 1 week of hire to confirm all trainings are compliant,including the 8 hours of annual caregiver training.	

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	file lacked documented evidence of eight hours of annual caregiver training. Employee #24 Employee #24 was hired by the facility as an AL Lead Med Tech with a start date of 03/31/2021. Employee #24's personnel file lacked documented evidence of eight hours of annual caregiver training. On 08/29/2024 at 2:29 PM, during an interview with the Business Office Director and the Administrator, the Business Office Director explained caregiver training was required for any employee who provided care to residents. Eight hours of training was required annually. On 08/29/2024 at approximately 3:15 PM, the Business Office Director provided the Attestation of Compliance form, signed and dated 08/29/2024, confirming a thorough review of the personnel records was conducted to determine compliance and any noncompliance found. The Business Office Director verbalized the information provided on the Personnel Checklist was accurate. On 09/03/2024, a review of the additional documentation submitted by the facility related to staff training was completed and did not include documented evidence of annual caregiver training for Employee #3, #17, #22, and #24. Severity: 2 Scope: 1			
0102 SS= D	Personnel File - TB Screening - NAC 449.200 Personnel files. 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (d) The health certificates required pursuant to chapter 441A of NAC for the employee; Inspector Comments: Based on record review and interview, the facility failed to provide documented evidence 2 of 25 sampled employees had a physical examination prior to working at the facility (Employee #23 and #25) and 4 of 25 sampled employees met the requirements concerning tuberculosis (TB) testing (Employee #5, #7, #21, and #24). Findings include: On 08/29/2024 at 10:21 AM, the Business Office Director was provided the Personnel Checklist to complete for 25 sampled employees. The Business Office	0102	We will ensure all pre-hire requirements arecompleted and documents in hand prior to employees to start or on start date. We have already provided evidence of physicalexam for employee #23. Employee#25 was previously employed from7/10/22 to 7/1/23 and rehired within 60days. A physical exam had been providedduring the initial hire timeframe. On 8/30/24,BOD placed request to Concentrafor initial physical to be sent.	09/05/2024

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	Director returned the partially completed checklist on 08/29/2024, and provided additional documentation related to personnel files for sampled employees on 09/02/2024 via electronic mail, with the following information: Physical Examinations Employee #23 Employee #23 was hired by the facility as a Health Services Assistant with a start date of 08/12/2024. Employee #23's personnel file included a physical examination dated 08/19/2024. Employee #23's personnel file lacked documented evidence a physical examination was completed prior to Employee #23's start date. Employee #25 Employee #25 was hired by the facility as a Lifestyle Assistant with a start date of 10/31/2023. Employee #25's personnel file lacked documented evidence a physical examination was completed prior to Employee #25's start date. TB Employee #5 Employee #5 was hired by the facility as a Memory Support Lead Medication Technician (MS Lead Med Tech) with a start date of 06/07/2023. Employee #5's personnel file included a TB Quantiferon lab test dated 06/06/2023. The facility failed to provide documented evidence of TB testing for Employee #5 by 06/30/2024. Employee #7 Employee #7 was hired by the facility as a MS Lead Med Tech with a start date of 01/12/2023. Employee #7's personnel file included a TB Quantiferon lab test dated 01/06/2023. The facility failed to provide documented evidence of TB testing for Employee #7 by 01/31/2024. Employee #21 Employee #21 was hired by the facility as a Memory Support Care Partner with a start date of 07/12/2023. Employee #21's personnel file included a TB Quantiferon lab test dated 07/10/2023. The facility failed to provide documented evidence of TB testing for Employee #21 by 07/31/2024. Employee #24 Employee #24 was hired by the facility as an Assisted Living Lead Medication Technician with a start date of 03/31/2021. Employee #24's personnel file included an annual TB test dated 01/04/2023. The facility failed to provide documented evidence of TB testing for Employee #24 for 2024. On 08/29/2024 at 2:29 PM, during an interview with the Business Office Director and the Administrator, the Business Office		On9/5/24- Personnel #5, # 7, # 21, & 24 annual TB completed. We will monitor compliance on an ongoing basis. More specifically, the Business OfficeDirector and or designee will complete a full Reliasaudit within 1 week of hire to confirm physical exams and TB testing have beendone.	

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	Director explained physical examinations were required for all employees and were to be done prior to the employee's start date. TB testing was required for all employees prior to start of employment and annually thereafter. On 08/29/2024 at approximately 3:15 PM, the Business Office Director provided the Attestation of Compliance form, signed and dated 08/29/2024, confirming a thorough review of the personnel records was conducted to determine compliance and any noncompliance found. The Business Office Director verbalized the information provided on the Personnel Checklist was accurate. Severity: 2 Scope: 1			
0104 SS= C	Personnel Files - Background Checks - NAC 449.200 Personnel files. (NRS 449.0302) 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (f) Evidence of compliance with NRS 449.122 to 449.125, inclusive. Inspector Comments: Based on record review and interview, the facility failed to ensure a Nevada Automated Background System (NABS) clearance was completed under the current facility license for all employees working in the facility. Findings include: On 08/29/2024, the employee roster report under provider number 11048 in NABS was blank. On 08/29/2024 at 2:39 PM, during an interview with the Administrator and the Business Office Manager, the Administrator explained the Administrator was not aware the facility had a new NABS account following a change of ownership. The Administrator confirmed all facility employees were entered into NABS using the provider number 9414. The current license number was 11048. The change of ownership was approved on 10/31/2023. Severity: 1 Scope: 3	0104	On 8/29/24 the Administrator contacted ToddSouth to update NABS account following the change of ownership. Administrator willensure the correct the NABS account to enter information going to forward.	08/29/2024

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0451 SS= D	First Aid & CPR - NAC 449.231 First aid and cardiopulmonary resuscitation. (NRS 449.0302) 2. A first-aid kit must be available at the facility. The first-aid kit must include, without limitation: (a) A germicide safe for use by humans; (b) Sterile gauze pads; (c) Adhesive bandages, rolls of gauze and adhesive tape; (d) Disposable gloves; (e) A shield or mask to be used by a person who is administering cardiopulmonary resuscitation; and (f) A thermometer or other device that may be used to determine the bodily temperature of a person. Inspector Comments: Based on observation and interview, the facility failed to ensure a first aid kit contained a cardiopulmonary resuscitation (CPR) mask. Findings include: On 08/29/2024, during the facility tour, the first aid kit in the Memory Support Unit did not contain a CPR mask. On 08/29/2024 at 10:09 AM, a Medication Technician verbalized the first aid kit did not contain a CPR mask. On 08/29/2024 at 10:11 AM, the Memory Support Director confirmed the first aid kit did not contain a CPR mask. Severity: 2 Scope: 1	0451	CPR mask was added in First Aid kit8/29/24. On an ongoing basis to monitorcompliance, Memory Care Support Director and or designee will audit first aidkit in memory support on a monthly basis.	08/29/2024

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0859 SS= D	Medical Care of Resident After Illness - NAC 449.274 and R043-22 Medical care of resident after illness, injury or accident; periodic physical examination of resident; rejection of medical care by resident; written records. (NRS 449.0302) 5. Before admission and each year after admission, or more frequently if there is a significant change in the physical condition of a resident, the facility shall obtain the results of a general physical examination of the resident by a qualified provider of health care in accordance with NRS 449.1845. The resident must be cared for pursuant to any instructions provided by the qualified provider of health care. Inspector Comments: Based on clinical record review, document review and interview, the facility failed to ensure an annual general physical examination, with a review of systems, was completed for 1 of 25 sampled residents (Resident #3). Findings include: Resident #3 Resident #3 was admitted to the facility on 12/02/2022, with diagnoses including mild dementia, and hypertension. Resident #3's clinical record documented an initial physical exam completed on 12/07/2022. Resident #3's clinical record lacked documented evidence of a physical exam completed for 2024. On 08/29/2024 at 11:26 AM, the Administrator confirmed Resident #3's annual physical exam was not completed timely for 2024. Severity: 2 Scope: 1	0859	Resident #3 request for physical was faxed tophysician 8/29/24 and received back completed on 9/11/24. On an ongoing basis to monitor compliance, the Memory Care SupportDirector and or designee will audit resident annual physicals in memory supporton a monthly basis.	08/29/2024
0878 SS= D	Medication/OTCS, Supplements, Change Order - NAC 449.2742 and R043-22 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 5. An over-the-counter medication or a dietary supplement may be given to a resident only if the resident's physician , physician assistant or advanced practice registered nurse has approved the administration of the medication or supplement in writing or the facility is ordered to do so by another physician, physician assistant or advanced practice registered nurse. The over-the-counter medication or dietary supplement must be administered in accordance with the written instructions of the physician,	0878	Resident #1Vit D gummies were brought in by family members on 8/29/24. Omeprazole DR was label was created for OTC. Allegra had a change order sticker placed8/29/24. Resident #12 change order sticker was placed onhaloperidol 1.5mg bottle on 8/29/24. Resident #6 lorazepam and	08/30/2024

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	physician assistant or advanced practice registered nurse. The administration of over-the-counter medications and dietary supplements must be included in the record required pursuant to paragraph (b) of subsection 1 of NAC 449.2744. 6. Except as otherwise provided in this subsection, a medication prescribed by a physician, physician assistant or advanced practice registered nurse must be administered as prescribed by the physician, physician assistant or advanced practice registered nurse. If a physician, physician assistant or advanced practice registered nurse orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order; (2) Indicate on the container of the medication that a change has occurred; and (3) Note the change in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; (b) Within 5 days after the change is ordered, a copy of the order or prescription signed by the physician, physician assistant or advanced practice registered nurse must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; and (c) If the label prepared by a pharmacist does not match the order or prescription written by a physician, physician assistant or advanced practice registered nurse, a physician, registered nurse or pharmacist must interpret that order or prescription and, within 5 days after the change is ordered, the interpretation must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744. Inspector Comments: Based on observation, interview, and record review the facility failed to ensure 1) a scheduled medication had a label for indication of use and administration for 1 of 25 sampled residents (Resident #1); 2) medication containers indicated a change in medication for 3 of 25 sampled residents (Resident #1, #12, and #6), 3) medications were on-site and available to administer to a resident for 2 of 25 sampled residents (Resident #1 and #6), and 4) a discontinued medication was		morphine change ordersticker was applied 8/29/24. Tussin Dextromethorphan and Guaifenesin DM wasrequested for delivery and received 8/30/24. Acetaminophen was removed from card in front of surveyor 8/29/24. On an ongoing basisto monitor compliance, the Memory Care Support Director and or designee will reviewall new orders with pharmacy, hospice or outside pharmacy to ensure timelydelivery. Weekly medication cart auditswill also be completed by Memory Support Director to ensure change orderstickers are corrected	

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	removed from the medication cart for 1 of 25 sampled residents (Resident #6). Findings include: Resident #1 Resident #1 was admitted to the facility on 09/15/2023, with diagnoses including dementia and asthma. Resident #1's August 2024 Medication Administration Record (MAR) documented the following: -Allegra Allergy 180 milligram (mg) tablets. Take one tablet by mouth daily. -Vitamin D3 50 microgram (mcg) (2000 UT) Chew. Take one gummy by mouth daily. -Omeprazole DR 20 mg tablets. Take one tablet by mouth 30 minutes before morning meal. Resident #1's medication containers documented the following: -Allegra Allergy 60 mg tablets. Take one tablet by mouth daily. -Vitamin D3 125 mcg capsule. Take one capsule by mouth daily. -Omeprazole DR lacked instructions for indication of use and the resident's name. Resident #1's physician's orders dated 10/06/2022, documented the following: -Allegra Allergy 180 milligram (mg) tablets. Take one tablet by mouth daily. -Vitamin D3 50 microgram (mcg) (2000 UT) Chew. Take one gummy by mouth daily. -Omeprazole DR 20 mg tablets. Take one tablet by mouth 30 minutes before morning meal. On 08/29/2024 at 1:23 PM, the Medication Technician confirmed Resident #1's Allegra bottle did not have a change order label to indicate there was a change in the resident's medication, confirmed Resident #1's Vitamin D gummy's were not onsite and available to administer to Resident #1, and confirmed the resident's Omeprazole DR lacked an administration label with instructions and the resident's name. Resident #12 Resident #12 was admitted to the facility on 08/01/2022, with diagnoses including dementia, cerebral atherosclerosis and repeated falls. Resident #12's August 2024 MAR documented Haloperidol 1.5 mg tablet. Take one tablet by mouth as needed or before showers if patient was agitated. Resident #12's medication bottle on-site documented Haloperidol 0.5 mg tablet. Take one tablet by mouth every four hours as needed before showers if patient was agitated. Resident #12's physician's order dated 03/08/2024, documented Haloperidol 0.5 mg tablet. Take one tablet as needed			

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	before showers if patient is agitated. On 08/29/2024 at 1:16 PM, the Medication Technician verbalized Resident #12's MAR and physician's order did not match the medication on-site, indicating the medication needed a change order sticker. The Medication Technician confirmed the medication on-site did not have a change order sticker affixed to the bottle indicating a change in the medication. Resident #6 Resident #6 was admitted to the facility on 01/08/2023, with diagnoses including acute respiratory failure, pneumonia, and Alzheimer's dementia. Resident #6's August 2024 MAR documented the following: - Lorazepam 0.5 mg tablet, take one tablet by mouth every four hours as needed. - Morphine Sulfate 10 mg tab, take one tablet by mouth every six hours as needed for pain/agitation/shortness of breath. - Acetaminophen 500 mg caplet, take one tablet by mouth every six hours as needed for moderate pain. Resident #6's medication containers documented the following: - Lorazepam 0.5 mg tablet, take one tablet by mouth every four hours as needed. - Morphine Sulfate 10 mg tab, take one tablet by mouth every six hours as needed for pain/agitation/shortness of breath. - Acetaminophen 500 mg caplet, take one tablet by mouth every six hours as needed for moderate pain. Resident #6's physician orders dated 08/28/2024, documented the following: -Lorazepam 0.5 mg, give by mouth three times per day crushed with water, about one teaspoon. -Morphine Sulfate 15 mg, give by mouth three times per day crushed with water, about one teaspoon. -Discontinue Acetaminophen. - Tussin Dextromethorphan and Guaifenesin (DM) 10 mg-100 mg/5 milliliters (ml) oral liquid, give 10 ml by mouth every six hours as needed for cough and congestion. On 08/29/2024 at 12:52 PM, the Medication Technician confirmed Resident #6's Lorazepam and Morphine Sulfate did not have a change order label to indicate there was a change in the resident's medication, confirmed Resident #6's Tussin DM was not onsite and available to administer to Resident #6, and confirmed Resident #6's Acetaminophen was discontinued and was not removed from the medication cart.			

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	Severity: 2 Scope: 1			
0895 SS= D	Administration of Medication Maintenance - NAC 449.2744 and R043-22 Administration of medication: Maintenance and contents of logs and records. (NRS 449.0302) 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall maintain: (b) A record of the medication administered to each resident. The record must include: (1) The type of medication administered; (2) The date and time that the medication was administered; (3) The date and time that a resident refuses, or otherwise misses, an administration of medication; (4) Instructions for administering the medication to the resident that reflect each current order or prescription of the resident's physician, physician assistant or advanced practice registered nurse, including, without limitation, whether the medication is to be administered according to a routine schedule or as needed; (5) Any change in an order or prescription of a resident ' s physician, physician assistant or advanced practice registered nurse,including, without limitation, the discontinuation of the medication; (6) Any time when the resident is out of the facility; and (7) Any mistakes made in the administration of medication. Inspector Comments: Based on observation, interview and clinical record review, the facility failed to ensure a Medication Administration Record (MAR) accurately reflected the correct medication dosage and frequency to be administered to a resident for 1 of 25 sampled residents (Resident #6). Findings include: Resident #6 Resident #6 was admitted to the facility on 01/08/2023, with diagnoses including acute respiratory failure, pneumonia, and Alzheimer's dementia. Resident #6's August 2024 MAR documented the following: - Lorazepam 0.5 mg tablet, take one tablet by mouth every four hours as needed. - Morphine Sulfate 10 mg tab, take one tablet by mouth every six hours as needed for pain/agitation/shortness of breath. - Acetaminophen 500 mg caplet, take one tablet by mouth every six hours as needed	0895	Please see Tag 0878 above for actions taken with respect toResident #6. In situations whereresident has brought their own medication with them at admission and there hasnot been sufficient time for an eMAR to populate, Memory Care Support Directoror designee will confirm there is a paper MAR with the appropriate informationfor each medication, including confirming available doses of medication matchthe physician’s order.	08/30/2024

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	for moderate pain. Resident #6's physician orders dated 08/28/2024, documented the following: -Lorazepam 0.5 mg, give by mouth three times per day crushed with water, about one teaspoon. -Morphine Sulfate 15 mg, give by mouth three times per day crushed with water, about one teaspoon. -Discontinue Acetaminophen. -Tussin Dextromethorphan and Guaifenesin (DM) 10 mg-100 mg/5 milliliters (ml) oral liquid, give 10 ml by mouth every six hours as needed for cough and congestion. On 08/29/2024 at 12:52 PM, the Medication Technician confirmed the doses of the available Lorazepam and Morphine Sulfate did not match the dosage and/or frequency of the medication as documented on the resident's physician order, the Acetaminophen had not been discontinued and removed from the MAR per physician orders, and the Tussin DM was entered onto the MAR per physician orders. Severity: 2 Scope: 1			

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0905 SS= D	Administration of Medication Restrictions - NAC 449.2746 Administration of medication: Restrictions concerning medication taken as needed by resident; written records. (NRS 449.0302) 1. A caregiver employed by a residential facility shall not assist a resident in the administration of a medication that is taken as needed unless: (a) The resident is able to determine his or her need for the medication; (b) The determination of the resident ' s need for the medication is made by a medical professional qualified to make that determination; or (c) The caregiver has received written instructions indicating the specific symptoms for which the medication is to be given, the exact amount of medication that may be given and the frequency with which the medication may be given. Inspector Comments: Based on interview, clinical record review, and document review, the facility failed to ensure written instructions indicating the specific symptom (s) for which an as needed (PRN) medication was to be administered to a resident was documented for 1 of 25 sampled residents (Resident #6). Findings include: Resident #6 Resident #6 was admitted to the facility on 01/08/2023, with diagnoses including acute respiratory failure, pneumonia, and Alzheimer's dementia. Resident #6's August 2024 Medication Administration Record (MAR) documented Lorazepam 0.5 mg tablet, take one tablet by mouth every four hours as needed. The MAR lacked the symptom for which the medication was ordered to treat. Resident #6's physician orders dated 02/08/2024, documented Lorazepam 0.5 mg take one tablet by mouth every four hours as needed. The physician order lacked the symptom for which the medication was ordered to treat. On 08/29/2024 at 12:52 PM, the Medication Technician verbalized Resident #6's August 2024 MAR and physician order lacked the symptom for which the medication was ordered to treat and should have obtained a clarification order to specify the symptom. Severity: 2 Scope: 1	0905	On August 29, 2024, Resident #6 orders wererequested from the hospice for signs and symptoms for PRN medications 8/29/24. Memory Care Support Director educated hospice company on AssistedLiving requirements so that future orders comply with regulations. Memory Care Support Director or designee will audit resident filesand ensure orders describe symptoms it is supposed to treat.	08/29/2024

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0920 SS= F	Medication: Storage - NAC 449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. (NRS 449.0302) 1. Medication, including, without limitation, any over-the-counter medication, stored at a residential facility must be stored in a locked area that is cool and dry. The caregivers employed by the facility shall ensure that any medication or medical or diagnostic equipment that may be misused or appropriated by a resident or any other unauthorized person is protected. Medications for external use only must be kept in a locked area separate from other medications. A resident who is capable of administering medication to himself or herself without supervision may keep the resident ' s medication in his or her room if the medication is kept in a locked container for which the facility has been provided a key. 2. Medication stored in a refrigerator, including, without limitation, any over-the-counter medication, must be kept in a locked box unless the refrigerator is locked or is located in a locked room. Inspector Comments: Based on observation, document review, and interview, the facility failed to ensure resident medications were kept secured in the facility for 2 of 28 resident rooms with self-administering residents (Room #111 and #245) and resident medications were kept secured in the facility for 2 of 25 sampled residents (Resident #10 and #25). Findings include: On 08/28/2024 at 9:27 AM, Room #111 had the resident present. In an unlocked drawer in the bathroom was a bottle of Lorazepam 0.5 milligram (mg) tablets, a bottle of Meloxicam 7.5 mg tablets, a bottle of Spironolactone 25 mg tablets, a bottle of Metoprolol Tartrate 25 mg tablets, a bottle of Furosemide 20 mg tablets, and a bottle of Levothyroxine 112 microgram (mcg) tablets. On the bathroom counter was a bottle of Acetaminophen 500 mg caplets, a bottle of Famotidine 20 mg tablets, and a bottle of Calcium 600 mg tablets. The resident verbalized the room was not always locked when unoccupied. On 08/28/2024 at 9:27 AM, the Health Services Assistant confirmed the unsecured medications in Room #111. On 08/28/2024	0920	Resident#10 was re-educated on medication storage policy in Assisted Living. Resident #25 was re-educatedon medication storage policy and Clearwater’s responsibility with medicationstorage. Resident #20 physician wascontacted for orders for all medications in room. Room 111 was re-educated on medication storage policyand Clearwater’s responsibility with medication storage. On an ongoing weekly basis to monitor compliance, the HealthService Director and or designee will conduct a walk through inspection ofresident rooms.	08/29/2024

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	at 9:50 AM, Room #245 did not have the resident present. In the bathroom were two bottles of age related eye disease study (AREDS), two eye vitamin and mineral supplement soft gels, a bottle of Acetaminophen extended-release tablets, a bottle of Cephalexin 250 mg capsules, a bottle of allergy nasal spray, a bottle of Dorzolamide Hydrochloride (HCl) and Timolol Maleate Ophthalmic Solution, a bottle of Prednisolone Acetate Ophthalmic Suspension 1 percent (%), a bottle of Levofloxacin 750 mg tablets, a bottle of Furosemide 20 mg tablets, a bottle of Amoxicillin 500 mg capsules, Celecoxib 200 mg capsules, a bottle of Aspirin 81 mg tablets, a bottle of multivitamin multimineral supplement tablets, a bottle of Naproxen Sodium 220 mg tablets, a bottle of low dose Aspirin 81 mg coated tablets, and a bottle of Aspirin 325 mg tablets. On 08/28/2024 at 9:50 AM, the Health Services Assistant confirmed the unsecured medications in Room #245. On 08/28/2024 at 9:54 AM, the Health Services Assistant verbalized it was important to keep doors locked for residents with medications in room because anyone else in the facility could come into resident rooms and take the medications. Resident #10 Resident #10 was admitted to the facility on 09/24/2023, with diagnoses including primary hypertension, diabetes type II, and knee pain. On 08/29/2024 at 2:05 PM, the following were found in the bathroom in Resident #10's room: -Aleve pain relief, 220 mg tablets. -Pepto Bismol digestive relief liquid. -Imodium anti-diarrheal tablets On 08/29/2024 at 2:05 PM, the Health Services Director verbalized Resident #10 should not have any medication in the room without a physician's order. The Health Services Director confirmed the medications were present. Resident #25 Resident #25 was admitted to the facility on 07/25/2022, with diagnoses including severe arthritis and hypertension On 08/29/2024 at 2:25 PM, the following were found in the bathroom in Resident #25's room: -Nyquil tablets. -triamcinolone 1% cream. -Dulcolax chews. -Tylenol 325 mg tablets. On 08/29/2024 at 2:25 PM, the Health Services Director verbalized Resident #25 should not have any			

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	medication in the room without a physician's order. The Health Services Director confirmed the medications were present. Resident #20 Resident #20 was admitted to the facility on 07/26/2024, with diagnoses including hypertension and acute encephalopathy. On 08/29/2024 between 2:05 PM and 2:25 PM, the following were found in Resident #20's room: -Triamcinolone 1% cream. -Hydrocortisone 1% cream. -Tylenol 325mg tablets. -Ondansetron four mg tablets. On 08/29/2024 at approximately 2:30 PM, the Health Services Director verbalized Resident #20 should not have any medication in the resident's room without a physician's order. Severity: 2 Scope: 3			
0923 SS= D	Medication: Storage - NAC 449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. (NRS 449.0302) 3. Medication, including, without limitation, any over-the-counter medication or dietary supplement, must be: (a) Plainly labeled as to its contents, the name of the resident for whom it is prescribed and the name of the prescribing physician; and (b) Kept in its original container until it is administered. Inspector Comments: Based on observation, record review and interview, the facility failed to properly label over-the-counter (OTC) medications with the resident's name and prescribing physician's name for 2 of 25 sampled residents (Resident #11 and #1). Findings include: Resident #11 Resident #11 was admitted to the facility on 02/21/2024, with a diagnosis of dementia. A physician's order dated 02/26/2024, documented Glucosamine 1500 Complex Capsules, take two capsules by mouth daily for joint pain. A physician's order dated 02/21/2024, documented PreserVision AREDS Soft Gels, take one soft gel by mouth twice a day for eye health. On 08/29/2024 at 1:31 PM, during a review of Resident #11's medications, one bottle of Glucosamine 1500 Complex Capsules, and one bottle of PreserVision AREDS Soft Gels lacked the resident's name and the physician's name. On 08/29/2024 at 1:34 PM, the Medication Technician confirmed	0923	8/29/24 Resident 11’s Flucosamineand PreserVision medication was labeled by Memory Support Director withresident and physician’s name. On8/29/24 Resdient #1’s Omerprazole was also labeled with resident and physician’s nameby Memory Support Director. On an ongoing basis to monitor compliance, the Memory Care SupportDirector and or designee will audit all OTC medication to ensure correct labelsare placed.	08/29/2024

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	the resident's name and the physician's name were not documented on the medication containers for Glucosamine 1500 Complex Capsules and PreserVision AREDS Soft Gels. Resident #1 Resident #1 was admitted to the facility on 09/15/2023, with diagnoses including asthma and dementia. On 08/29/2024 at 1:23 PM, during a review of Resident #1's medications, one container of Omeprazole DR 20 mg tablets was available, however lacked the resident's name and physician's name. On 08/29/2024 at 1:27 PM, the Medication Technician confirmed the resident's name and physician's name were not documented on the medication container for Omeprazole. Severity: 2 Scope: 1			

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0938 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) 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he or she permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including, without limitation: (g) An evaluation of the resident ' s ability to perform the activities of daily living and a brief description of any assistance he or she needs to perform those activities. The facility shall prepare such an evaluation: (1) Upon the admission of the resident; (2) Each time there is a change in the mental or physical condition of the resident that may significantly affect his or her ability to perform the activities of daily living; and (3) In any event, not less than once each year. Inspector Comments: Based on record review and interview, the facility failed to ensure an Activities of Daily Living (ADL) assessment was completed annually for 1 of 25 residents (Resident #6). Findings include: Resident #6 Resident #6 was admitted to the facility on 01/08/2023, with diagnoses including acute respiratory failure, pneumonia, and Alzheimer's dementia. Resident #6's clinical record documented an ADL assessment dated 12/13/2022, unsigned. Resident #6's clinical record lacked documented evidence an ADL assessment had been completed since 12/13/2022. On 08/29/2024 at 11:01 AM, the Memory Support Director confirmed an annual ADL assessment was not completed for Resident #6 in 2023 or 2024, and verbalized the ADL assessment for 2022 was invalid as it was unsigned. Severity: 2 Scope: 1	0938	Our records show the following for Resident 6: Pre-Admission Assessment: 1/2/23 Move In Initial Assessment: 1/9/23 6 Month Review: 6/6/23 Change of Condition Assessment: 1/4/24 Change of Condition Assessment: 8/8/24 On an ongoing basis to monitor compliance, the Memory Care SupportDirector and or designee will audit resident files on a monthly basis toconfirm appropriate assessments undertaken.	08/29/2024
1037 SS= E	Care to Persons with Dementia - NAC 449.2768 and R043-22 Residential facility which provides care to persons with dementia: Training for employees. (NRS	1037	On 9/10/24, 3 hours Dementia training completedwith all care	09/10/2024

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	449.0302, 449.094) 1. Except as otherwise provided in subsection 2, the administrator of a residential facility which provides care to persons with any form of dementia shall ensure that: (a) Each employee of the facility who has direct contact with and provides care to residents with any form of dementia, including, without limitation, dementia caused by Alzheimer ' s disease, successfully completes: (3) If such an employee is licensed or certified by an occupational licensing board, at least 3 hours of continuing education in providing care to a resident with dementia, which must be completed on or before the anniversary date of the first date the employee was initially employed at the facility. The requirements set forth in this subparagraph are in addition to those set forth in subparagraphs (1) and (2), may be used to satisfy any continuing education requirements of an occupational licensing board, and do not constitute additional hours or units of continuing education required by the occupational licensing board. (4) If such an employee is a caregiver, other than a caregiver described in subparagraph (3), at least 3 hours of tier 2 training in providing care to a resident with dementia, which must be completed on or before the anniversary date of the first date the employee was initially employed at the facility. The requirements set forth in this subparagraph are in addition to those set forth in subparagraphs (1) and (2). Inspector Comments: Based on record review and interview, the facility failed to provide documented evidence 8 of 25 sampled employees completed the required minimum of three hours of training in providing care to a resident with dementia by the hire anniversary date (Employee #3, #4, #5, #10, #17, #21, #22, and #24). Findings include: On 08/29/2024 at 10:21 AM, the Business Office Director was provided the Personnel Checklist to complete for 25 sampled employees. The Business Office Director returned the partially completed checklist on 08/29/2024, and provided additional documentation related to personnel files for sampled employees on 09/02/2024 via electronic		staff for Assisted Living and Memory Support care. We will monitor compliance on an ongoing basis. More specifically, the Business OfficeDirector and or designee will complete a full Reliasaudit within 1 week of hire and annually to confirm all trainings arecompliant, including the dementia training.	

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	mail, with the following information: Employee #3 Employee #3 was hired by the facility as the Health Services Director with a start date of 04/14/2022. The Personnel Checklist lacked documented evidence of three hours of annual dementia training by 04/14/2024, for Employee #3. Employee #4 Employee #4 was hired by the facility as the Memory Support Director with a start date of 12/06/2022. The Personnel Checklist lacked documented evidence of three hours of annual dementia training by 12/06/2023, for Employee #4. Employee #5 Employee #5 was hired by facility as a Memory Support Lead Medication Technician (MS Lead Med Tech) with a start date of 06/07/2023. The Personnel Checklist lacked documented evidence of three hours of annual dementia training by 06/07/2024, for Employee #5. Employee #10 Employee #10 was hired by the facility as a Memory Support Care Partner (MS Care Partner) with a start date of 04/13/2023. The Personnel Checklist lacked documented evidence of three hours of annual dementia training by 04/13/2024, for Employee #10. Employee #17 Employee #17 was hired by the facility as an Assisted Living Care Partner (AL Care Partner) with a start date of 08/26/2022. The Personnel Checklist lacked documented evidence of three hours of annual dementia training by 08/26/2024, for Employee #17. Employee #21 Employee #21 was hired by the facility as a MS Care Partner with a start date of 07/12/2023. The Personnel Checklist lacked documented evidence of three hours of annual dementia training by 07/12/2024, for Employee #21. Employee #22 Employee #22 was hired by the facility as an Assisted Living Medication Technician (AL Med Tech) with a start date of 07/27/2021. The Personnel Checklist lacked documented evidence of three hours of annual dementia training by 07/27/2024, for Employee #22. Employee #24 Employee #24 was hired by the facility as an AL Lead Med Tech with a start date of 03/31/2021. The Personnel Checklist lacked documented evidence of three hours of annual dementia training by 03/31/2024, for Employee #24. On 08/29/2024 at 2:29 PM, during an interview with the Administrator and the Business Office Director, the			

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	Business Office Director explained all employees providing care to residents were required to complete dementia training upon hire and annually thereafter. On 08/29/2024 at approximately 3:15 PM, the Business Office Director provided the Attestation of Compliance form, signed and dated 08/29/2024, confirming a thorough review of the personnel records was conducted to determine compliance and any noncompliance found. The Business Office Director verbalized the information provided on the Personnel Checklist was accurate. On 09/03/2024, a review of the additional documentation submitted by the facility related to staff training was completed and did not include documented evidence of annual dementia training for Employee #3, #4, #5, #10, #17, #21, #22, and #24. Severity: 2 Scope: 2			
1100 SS= F	Weights - Training/Consent - NAC 449.1985 (4) 4. A caregiver may weigh a resident of a residential facility only if: (a) The caregiver has received training on the manner in which to weigh a person that meets the requirements of subsections 5 and 6; and (b) The resident has consented to being weighed by the caregiver. Inspector Comments: Based on record review and interview, the facility failed to obtain resident or resident representative consent to obtain monthly resident weight measurements. Findings include: On 08/29/2024 at 8:43 AM, the Health Services Director verbalized caregiver staff members obtained weight measurements from all residents on a monthly basis. On 08/29/2024 at 1:41 PM, the Administrator confirmed all residents weight measurements were taken monthly and the facility had not obtained consents for weight measurements from any resident or resident representative. The Administrator verbalized not having been aware of this requirement. Severity: 2 Scope: 3	1100	Consents will be obtained prior to takingweights. Moving forward consentdocumentation will be included in all admission paperwork. For existingresidents we will verbally ask for consent prior taking weights and documentthe consent in the resident record.	11/22/2024
1300 SS= C	Discrimination prohibited - NRS 449.101 Discrimination prohibited; development of antidiscrimination policy; posting of nondiscrimination statement and certain other information; construction of section.	1300	On November11, 2024, posted in Memory Support Unit non-discrimination statement and	11/11/2024

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CLEARWATER AT RANCHARRAH	5255 KIETZKE LANE, RENO, NEVADA ,89511

(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
	[Effective January 1, 2020.] 1. A medical facility, facility for the dependent or facility which is otherwise required by regulations adopted by the Board pursuant to NRS 449.0303 to be licensed and any employee or independent contractor of such a facility shall not discriminate in the admission of, or the provision of services to, a patient or resident based wholly or partially on the actual or perceived race, color, religion, national origin, ancestry, age, gender, physical or mental disability, sexual orientation, gender identity or expression or human immunodeficiency virus status of the patient or resident or any person with whom the patient or resident associates. 2. A medical facility, facility for the dependent or facility which is otherwise required by regulations adopted by the Board pursuant to NRS 449.0303 to be licensed shall: (a) Develop and carry out policies to prevent the specific types of prohibited discrimination described in the regulations adopted by the Board pursuant to NRS 449.0302 and meet any other requirements prescribed by regulations of the Board; and (b) Post prominently in the facility and include on any Internet website used to market the facility the following statement: [Name of facility] does not discriminate and does not permit discrimination, including, without limitation, bullying, abuse or harassment, on the basis of actual or perceived race, color, religion, national origin, ancestry, age, gender, physical or mental disability, sexual orientation, gender identity or expression or HIV status, or based on association with another person on account of that person's actual or perceived race, color, religion, national origin, ancestry, age, gender, physical or mental disability, sexual orientation, gender identity or expression or HIV status. 3. In addition to the statement prescribed by subsection 2, a facility for skilled nursing, facility for intermediate care or residential facility for groups shall post prominently in the facility and include on any Internet website used to market the facility: (a) Notice that a patient or resident who has experienced prohibited discrimination may file a complaint with the Division; and (b) The contact information for the Division. 4.		theState Agency’s contact information for filing a non-discrimination complaint. We have added a link to the anti-discrimination policy as a banner onthe top of the ClearwateratRancharrah.com as well as on the footer of thewebsite. Both will be present on every page of the website. A user can closeout on the banner by clicking the “X” on the top right of the screen; however,the banner will pop up anytime the user revisits the website. When a user clicks on the banner or link in thefooter, a separate tab will open where they will view the attachedanti-discrimination policy	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11048	A. BUILDING _____ B. WING _____	08/29/2024

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	The provisions of this section shall not be construed to: (a) Require a medical facility, facility for the dependent or facility which is otherwise required by regulations adopted by the Board pursuant to NRS 449.0303 to be licensed or an employee or independent contractor thereof to take or refrain from taking any action in violation of reasonable medical standards; or (b) Prohibit a medical facility, facility for the dependent or facility which is otherwise required by regulations adopted by the Board pursuant to NRS 449.0303 to be licensed from adopting a policy that is applied uniformly and in a nondiscriminatory manner, including, without limitation, such a policy that bans or restricts sexual relations. Inspector Comments: Based on observation and interview, the facility failed to ensure a non-discrimination statement with the State Agency's contact information for filing a complaint was posted in the Memory Support Unit and on the facility's Internet website used to market the facility. Findings include: Memory Support Unit On 08/29/2024, the locked Memory Support Unit lacked a posted non-discrimination statement or the State Agency's contact information for filing a discrimination complaint. On 08/29/2024 at 9:27 AM, the Memory Support Director confirmed the lack of a posted non-discrimination statement, including the State Agency's contact information for filing a discrimination complaint, in the Memory Support Unit. Internet Website On 08/29/2024 at 9:47 AM, the facility's Internet website, used to market the facility, lacked a non-discrimination statement or the State Agency's contact information for filing a discrimination complaint. On 08/29/2024 at 9:55 AM, the Administrator confirmed the facility's Internet website lacked a non-discrimination statement, including the State Agency's contact information for filing a discrimination complaint. Severity: 1 Scope: 3			