

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/05/2024
NAME OF PROVIDER OR SUPPLIER CLEARWATER AT RANCHARRAH			STREET ADDRESS, CITY, STATE, ZIP CODE 5255 KIETZKE LANE, RENO, NEVADA ,89511	
(X4) ID PREFIX TAG 0000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG 0000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a State Licensure complaint investigation conducted at your facility on 12/05/2024. 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 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 92. Five resident files and five employee files were reviewed. The facility received a grade of A. One complaint was investigated. Complaint #NV00072881 with the following allegations could not be substantiated due to lack of sufficient evidence: Allegation #1: The facility failed to maintain a safe and comfortable temperature for residents due to a broken HVAC system. Allegation #2: The facility failed to notify a resident's responsible party of difficulties keeping a resident room at a safe temperature per regulatory requirement. Investigation into the allegations included: Observation of the memory care unit for cleanliness and odors, residents interacting with staff and other residents, residents receiving care, temperature in resident rooms and common areas. Interviews were conducted with the Maintenance Director, the Memory Support Assistant, and the Executive Director. Document review included the facility's Environmental Safety Policy, Emergency Preparedness Plan, and Infection Prevention and Control Plan. 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,			

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.

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FORM APPROVED
OMB NO. 0938-0391

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	or local laws. Please keep a copy of this statement of deficiency for your records.						