

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 11048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/29/2025
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 mandatory re-grading survey conducted at your facility on 01/29/2025. 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, with 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 117. 15 resident records and 15 employee records were reviewed. The facility received a grade of A. 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:			

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

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 11048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/29/2025
NAME OF PROVIDER OR SUPPLIER CLEARWATER AT RANCHARRAH		STREET ADDRESS, CITY, STATE, ZIP CODE 5255 KIETZKE LANE, RENO, NEVADA ,89511		
(X4) ID PREFIX TAG 0065 SS= D	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG 0065	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE 09/06/202 4
	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 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.		On September 6, 2024, we did a complete audit of our employee files to confirm each had the required training. We pulled employees #3, # 17, 22 and #24 in order to allow them to complete 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 full Relias audit within 1 week of hire to confirm all trainings are compliant, including the 8 hours of annual caregiver training.	

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 11048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/29/2025
NAME OF PROVIDER OR SUPPLIER CLEARWATER AT RANCHARRAH		STREET ADDRESS, CITY, STATE, ZIP CODE 5255 KIETZKE LANE, RENO, NEVADA ,89511		
(X4) ID PREFIX TAG 0102 SS= D	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 employee record review and interview, the facility failed to ensure annual tuberculosis (TB) screenings had been completed for 3 of 15 sampled employees (Employee #3, #8 and #13), pursuant to Nevada Administrative Code, Chapter 441A.375. Findings include: Employee #3 Employee #3 was hired on 03/31/2021 as an Assisted Living Medication Technician. Employee #3's record documented a one-step annual TB screening with a read date of 01/06/2023, and a negative result. Employee #3's record lacked documented evidence an annual TB screening had been completed in 2024. Employee #8 Employee #8 was hired on 12/06/2022 as the Memory Support Director. Employee #8's record lacked documented evidence of a completed TB screening. Employee #13 Employee #13 was hired on 01/12/2023 as a Memory Support Medication Technician. Employee #13's record documented a QuantiFERON TB screening with a final report determination date of 01/06/2023, and a negative result. Employee #13's record lacked documented evidence an annual TB screening had been completed in 2024. On 01/29/2025 at 11:40 AM, the Business Office Manager (BOM) confirmed annual TB screenings had not been completed for Employees #3, #8, and #13. The BOM verbalized having been responsible for ensuring the completion of TB screenings for facility staff but had missed Employees #3, #8, and #13's TB annual screenings. Severity: 2 Scope: 1	ID PREFIX TAG 0102	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) <i>On 2/3/25 Personnel #3 and #13 were sent to the lab for 1 step QuantiFERON testing and on 2/5/25 #8 annual signs and symptoms was completed. Executive Director will audit compliance with TB testing requirements every quarter to ensure compliance.</i>	(X5) COMPLETION DATE 02/05/2025

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 11048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/29/2025
NAME OF PROVIDER OR SUPPLIER CLEARWATER AT RANCHARRAH		STREET ADDRESS, CITY, STATE, ZIP CODE 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
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.	0104	On 8/29/24 the Administrator contacted Todd South to update NABS account following the change of ownership. Administrator will ensure the correct the NABS account to enter information going to forward.	08/29/2024
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.	0451	CPR mask was added in First Aid kit 8/29/24. On an ongoing basis to monitor compliance, Memory Care Support Director and or designee will audit first aid kit in memory support on a monthly basis.	08/29/2024
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.	0859	Resident #3 request for physical was faxed to physician 8/29/24 and received back completed on 9/11/24. On an ongoing basis to monitor compliance, Memory Support Director and or designee will audit resident annual physicals in memory support on a monthly basis.	09/11/2024
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	0878	Resident #1 Vit 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 placed 8/29/24. Resident #12 change order sticker was placed on haloperidol 1.5mg bottle on 8/29/24. Resident #6 lorazepam and morphine change order sticker was	08/30/2024

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 11048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/29/2025
NAME OF PROVIDER OR SUPPLIER CLEARWATER AT RANCHARRAH		STREET ADDRESS, CITY, STATE, ZIP CODE 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
	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, 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.		applied 8/29/24. Tussin Dextromethorphan and Guaifenesin DM was requested for delivery and received 8/30/24. Acetaminophen was removed from card in front of surveyor 8/29/24. On an ongoing basis to monitor compliance, the Memory Care Support Director and or designee will review all new orders with pharmacy, hospice or outside pharmacy to ensure timely delivery. Weekly medication cart audits will also be completed by Memory Support Director to ensure change order stickers are corrected	

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 11048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/29/2025
NAME OF PROVIDER OR SUPPLIER CLEARWATER AT RANCHARRAH		STREET ADDRESS, CITY, STATE, ZIP CODE 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
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.	0895	Please see Tag 0878 above for actions taken with respect to Resident #6. In situations where resident has brought their own medication with them at admission and there has not been sufficient time for an eMAR to populate, Memory Care Support Director or designee will confirm there is a paper MAR with the appropriate information for each medication, including confirming available doses of medication match the physician's order	08/29/2024
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.	0905	On August 29, 2024, Resident #6 orders were requested from the hospice for signs and symptoms for PRN medications 8/29/24. Memory Care Support Director educated hospice company on Assisted Living requirements so that future orders comply with regulations. Memory Care Support Director or designee will audit resident files and ensure orders describe symptoms it is supposed to treat.	08/29/2024
0920 SS= D	Medication: Storage - NAC 449.2748 Medication: Storage; duties upon discharge,	0920	<i>On 1/29/25 all found medications were</i>	01/29/2025

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 11048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/29/2025
NAME OF PROVIDER OR SUPPLIER CLEARWATER AT RANCHARRAH		STREET ADDRESS, CITY, STATE, ZIP CODE 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
	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 12 sampled residents (Resident #9 and #14). Findings include: Resident #9 Resident #9 was admitted to the facility on 03/09/2024, with diagnoses including primary hypertension, and hyperlipidemia. On 01/29/2025 at 11:20 AM, the following were found in the bathroom in Resident #9's room: -a container of topical chest rub & analgesic ointment -Refresh Tears -Terbinafine Hydrochloride AntiFungal Cream On 01/29/2025 at 12:40 PM, the Health Services Director verbalized Resident #9 should not have any medications in the room without a physician's order to self administer. The Health Services Director confirmed the medications were present. Resident #14 Resident #14 was admitted to the facility on 05/10/2023, with diagnoses including hypertension, depression and chronic hyponatremia. On 01/29/2025 at 11:15 AM, the following was found in the bathroom in Resident #14's room: -Tylenol 325 milligram tablets. On 01/29/2025 at 11:17 AM, the Medication Technician verbalized Resident		<i>removed from resident #9's room. On1/29/24 resident #14's expired Tylenol medication was removed anddestroyed. Both residents' were educatedon medication storage policy, including the requirements that all medicationincluding that all over the counter medication must have a doctor's order. On an ongoing weekly basis to monitorcompliance, the HSD and or designee will conduct a walk-through inspection ofresident rooms. If medication is found against our medication storage policy,we will remove the medications and store them appropriately and obtain anynecessary doctor order.</i>	

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 11048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/29/2025
NAME OF PROVIDER OR SUPPLIER CLEARWATER AT RANCHARRAH		STREET ADDRESS, CITY, STATE, ZIP CODE 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
	#14 should not have any medication in the room without a physician's order and the Tylenol was expired and should be destroyed. The facility policy titled "Medication Storage - Centrally Stored Medication," dated 12/13/2024, documented all medication including over the counter medications were kept in a locked storage at all times. The facility policy titled "Resident Self-Management and Storage of Medication," dated 12/01/2023, documented the Health Services Director would ensure there was a physician's order in place indicating the resident was able to self administer and safely store their medications. Severity: 2 Scope: 1			
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.	0923	8/29/24 Resident 11's Flucosamine and Preser Vision medication was labeled by Memory Support Director with resident and physician's name. On 8/29/24 Resident #1's Omeprazole was also labeled with resident and physician's name by Memory Support Director. On an ongoing basis to monitor compliance, the Memory Care Support Director and or designee will audit all OTC medication to ensure correct labels are placed.	08/29/2024

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 11048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/29/2025
NAME OF PROVIDER OR SUPPLIER CLEARWATER AT RANCHARRAH		STREET ADDRESS, CITY, STATE, ZIP CODE 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
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.	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 Support Director and or designee will audit resident files on a monthly basis to confirm appropriate assessments undertaken.	08/29/202 4

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 11048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/29/2025
NAME OF PROVIDER OR SUPPLIER CLEARWATER AT RANCHARRAH		STREET ADDRESS, CITY, STATE, ZIP CODE 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
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 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).	1037	On 9/10/24- 3 hours Dementia training completed with all care staff for Assisted Living and Memory Support care.	09/10/2024
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.	1100	Consents will be obtained prior to taking weights. Moving forward consent documentation will be included in all admission paperwork. For existing residents we will verbally ask for consent prior taking weights and document the 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 nondiscrimination statement and the State Agency's contact information for filing a nondiscrimination complaint. We have added a link to the antidiscrimination	11/11/2024

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 11048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/29/2025
NAME OF PROVIDER OR SUPPLIER CLEARWATER AT RANCHARRAH		STREET ADDRESS, CITY, STATE, ZIP CODE 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.		policy as a banner on the top of the ClearwateratRancharra.com as well as on the footer of the website. 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 the footer, a separate tab will open where they will view the attached anti-discrimination policy	

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 11048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/29/2025	
NAME OF PROVIDER OR SUPPLIER CLEARWATER AT RANCHARRAH		STREET ADDRESS, CITY, STATE, ZIP CODE 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) 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.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE