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	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**04/10/2025**

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 a complaint investigation conducted in your facility on 04/10/2025, in accordance with Nevada Administrative Code (NAC) Chapter 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 90. Five resident files were reviewed. Three complaints were investigated. Complaint #NV00073614 with the following allegations could not be substantiated due to lack of sufficient evidence: Allegation #1: A Resident's room did not have any heat. Allegation #2: Not following specialized diets. Allegation #3: The facility was not providing resident care when the resident had a personal caregiver coming in. Allegation #4: Medications were not being administered as prescribed Investigation into the allegations included: Observation of the memory care unit of 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 Director, and Operations Specialist. Record review of hospice plan of care, physician orders, progress notes, person centered service plans and service assessments, medication administration records and outside agency documentation. Document review of admission and discharge policy, person-centered service plan policy, basic care policy, personal care attendants policy, residence and care agreement, special diets policy, Abuse, Neglect and Exploitation policy, and personal rights policy. Complaint #NV00073647 with the allegations the facility did not have enough	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: APOLINARIO GOZON Title: Administrator Date: 04/25/2025

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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	staff in memory care could not be substantiated due to lack of sufficient evidence: Investigation into the allegations included: Observation of the memory care unit of residents interacting with staff and other residents, and residents receiving care. Interviews were conducted with the Memory Support Director, and Operations Specialist. Document review of facility schedules for memory care, and daily census. Complaint #NV00073724 with the following allegations could not be substantiated. Allegation #1: The facility failed to monitor a resident could not be substantiated due to lack of evidence. Allegation #2: The resident was not treated with dignity and respect could not be substantiated due to lack of evidence. Allegation #3: The facility did not provide care per physician order could not be substantiated due to lack of evidence. Allegation #4: The resident was not turned/positioned timely could not be substantiated due to lack of evidence. Allegation #5: The resident was left toileting unsupervised could not be substantiated due to lack of evidence. The investigation into the allegations included: Observations of residents in resident rooms, residents in the common areas, and staff and resident interactions. Interviews with three residents, a Caregiver, the Housekeeping Lead, the Health Services Director, the Memory Support Director, and the Operations Specialist. Record review of hospice plan of care, hospice interdisciplinary team reports, progress notes, person-centered service plans, health and Service assessments, medication administration records, and outside agency documentation. Document review of admission and discharge policy, person-centered service plan policy, falls policy, basic care policy, personal care attendants policy, housekeeping schedules, and residence and care agreement. The investigation revealed the Administrator failed to ensure the facility adhered to its admission and discharge policy (see Tag			

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	Y0615), and residents had a complete person-centered service plan for residents (see Tag Y0520). 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 following regulatory deficiencies were identified:			
0053 SS= E	Administrator's Responsibilities-Complete Rec - NAC 449.194 Responsibilities of administrator. (NRS 449.0302) The administrator of a residential facility shall: 4. Ensure that the records of the facility are complete and accurate. Inspector Comments: Based on record review, document review and interview, the facility failed to 1) adhere to it's Admission and Discharge policy, 2) complete the required documents for a resident's use of a personal attendant, and 3) provide care coordination for 2 of 5 sampled residents (Resident #2, and #3) Findings include: Resident #2 Resident #2 was admitted to the facility on 05/15/2021 and discharged on 03/05/2025, with diagnoses including heart disease, atrial fibrillation, mild cognitive impairment, neuropathy, peripheral, and chronic kidney disease. Resident #2's Residence and Care Agreement (Agreement) dated 05/12/2021, documented the Agreement lacked completion of Appendix D., Private Duty Aide Personnel Policies. Resident #3 Resident #3 was admitted to the facility on 02/21/2024, with diagnoses including of Alzheimer's disease, hypertension, gout and hypothyroidism. Resident #3's Residence and Care Agreement (Agreement) dated 02/21/2024, documented the Agreement lacked completion of Appendix D., Private Duty Aide Personnel Policies. On 04/10/2025 at 3:09 PM, Health Services Director (HSD) confirmed Resident #2 and #3 had personal	0053	TAG 0053 Plan of Correction 1) The facility will abet this citation by completing Appendix D - Private Duty Aide Personnel form for Resident #3 by April 30, 2025. Resident #2 moved out on March 8, 2025. 2) The Administrator or Designee will audit all resident files to ensure Appendix D is signed and/or completed by May 30, 2025. 3) The administrator or Designee will implement and adhere to Clearwater Admission and Discharge Policy and Private Duty Aide Policy to ensure continued compliance. All Directors will be re-trained with Clearwater Admission and Discharge Policy by May 30, 2025. 4) Health Services Director or Memory Support Director or Designee to ensure Private Duty Aide Roles and Responsibilities are outlined and included in the resident service plans. Current service plans will be updated to include roles and responsibilities by May 30, 2025. 5) The Administrator or Concierge will require Private Duty Aides to sign in at the concierge desk using AccuShield Kiosk and fill out form, Outside Agency Documentation Form before leaving the community.	05/30/2025

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	attendants and their respective Agreements were not completed. The HSD verbalized a resident with a personal attendant should have the documentation filled out completely so services were known and coordinated with the resident's service plan. The facility policy titled "Admission and Discharge Policies," dated 12/01/2023, documented all preadmission documentation was complete and in the resident's record. The facility Residence and Care Agreement, dated 04/05/2023, documented Section X., Other Personal Obligations, Subpart C., Private Duty Aides, must abide by the facilities policies for outside providers. The facility Residence and Care Agreement, dated 04/05/2023, documented Appendix D., Private Duty Aide Personnel Policies, each Attendant must complete and submit an Attendant Registration and Information Form. Attendants were restricted to providing the services listed on the resident's Statement of Authorized Services. Attendants would provide the facility a report regarding the resident's health status and the nature of the services provided to the resident. The Attendant must sign the log and provide all requested information at each visit to the facility. Severity: 2 Scope: 2			
0520 SS= D	Supervision and Treatment of Residents - NAC 449.259 and R043-22 Supervision and treatment of residents generally. (NRS 449.0302) 2. A person-centered service plan developed pursuant to this section must include, without limitation: (a) Provisions concerning activities of daily living, medication management, cognitive safety, assistive devices, special needs, social and recreational needs and involvement of ancillary services; (b) Protective supervision as necessary for the resident; (c) The manner in which all caregivers will be informed of the required supervision of the resident; (d) The manner in which the facility will ensure that the resident has the opportunity to attend the religious service of his or her choice and	0520	TAG 0520 Plan of Correction The Administrator and Health Service Director will ensure community complies with NAC 449.259 and R043-22 Supervision and treatment of residents generally. 1) The Health Service Director will develop a person-centered service plan for each resident that will include the following: a) Activities of Daily Living b) Medication Assistance c) Cognitive Safety d) Assistive Devices and/or Special Needs	05/15/2025

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	participate in personal and private pastoral counseling; (e) Permission for the resident to rest in his or her room at any time; (f) Permission for the resident to enter or leave the facility at any time if the resident: (1) Is physically and mentally capable of leaving the facility; and (2) Complies with the rules established by the administrator of the facility for leaving the facility; (g) Laundry services for the resident unless the resident elects in writing to make other arrangements; (h) The manner in which the facility will ensure that the resident's clothes are clean, comfortable and presentable; (i) A requirement that the facility must inform the resident or his or her representative of the actions that the resident should take to protect the resident's valuables; (j) A written program of activities for the resident that includes scheduled and unscheduled activities that are suited to his or her interests and capacities; Inspector Comments: Based on record review, document review and interview, the facility failed to ensure a resident's person-centered service plan (service plan) was developed to address the facility's treatment of a resident's personal care attendant and assistance with toileting for a resident with fall history for 1 of 5 sampled residents reviewed for service plans (Resident #2). Findings include: Resident #2 was admitted to the facility on 05/15/2021 and discharged on 03/05/2025, with diagnoses including heart disease, atrial fibrillation, mild cognitive impairment, neuropathy, peripheral, and chronic kidney disease. Resident #2's Service Plan dated 02/12/2025, lacked documented evidence of care coordination for the resident's personal care attendant. Resident #2's Service Plan, dated 02/12/2025, documented under the Need of Toileting, a Goal of maintain or maximize current level of functioning and resident did not require assistance. The Action documented the resident required physical assistance with		e) Protective Supervision 2) All staff will be in-serviced on reviewing person-centered Service Plans by May 15, 2025 3) Health Service Director and/or Memory Support Director will document care coordination with outside providers and/or Private Duty Aides in resident file. 4) Resident(s) at risk for falls will be evaluated per Clearwater Policy. The Health Service Director and/or Memory Support Director or Designee will develop person-centered actions and/or interventions to minimize and/or mitigate recurrence. Any change in the resident level of care will be communicated to staff and documented in resident file.	

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	all tasks related to toileting and lacked an action for toileting assistance which included the resident's fall history. Hospice Outside Agency Documentation for Skilled Nursing dated 01/05/2025, 01/14/2025, 01/21/2025, 01/23/2025, 01/28/2025, 01/31/2025, 02/04/2025, 02/07/2025, 02/11/2025, and 02/14/2025, documented Resident #2 was a fall risk and a two person assist for transfer for toileting. On 04/10/2025 at 2:46 PM, the Health Services Director (HSD) confirmed Resident #2 used a Personal Care Attendant and Resident #2's Service Plan lacked care coordination planning. The HSD verbalized a service plan for toileting assistance for a resident with fall history should include an action for toileting with staffing in pairs and to not leave the resident. The HSD confirmed Resident #2 had a fall history and needed assistance toileting and Resident #2's service plan lacked an action for toileting assistance to include toileting in pairs and to not to leave the resident when toileting. The HSD confirmed Resident #2's Service Plan had conflicting information with respect to the resident's need for assistance in the Goal and Action for toileting. The facility policy titled "Person-Centered Service Plans," dated 12/01/2023, documented the Person-Centered Service Plan was to be individualized based on the resident's needs and preferences. The facility policy titled "Falls," dated 12/01/2023, documented all residents would be evaluated for fall risk and their Person-Centered Service Plan would be developed and updated accordingly. Each resident's identified fall risk would be included in the resident's Person-Centered Service Plan. Severity: 2 Scope: 1			