Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9896	A. BUILDING _____ B. WING _____	08/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRACINA HOME CARE II, LLC	**1721 GLEN COVE CT, RENO, NEVADA ,89521**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a State Licensure annual grading survey conducted in your facility on 08/25/21. 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 is licensed for six Residential Facility for Group beds for elderly and disabled persons, Category II residents. The census at the time of the survey was four. Four resident files and four employee files 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 investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following deficiencies were identified:	0000		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | Name: JENNIFER LEWIS | Title: Owner/Manager | Date: 10/28/2021

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0870 SS= D	Medication Administration-Accuracy & Report - NAC 449.2742 Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall: (a) Ensure that a physician, pharmacist or registered nurse who does not have a financial interest in the facility: (1) Reviews for accuracy and appropriateness, at least once every 6 months the regimen of drugs taken by each resident of the facility, including, without limitation, any over-the-counter medications and dietary supplements taken by a resident; and (2) Provides a written report of that review to the administrator of the facility. (b) Include a copy of each report submitted to the administrator pursuant to paragraph (a) in the file maintained pursuant to NAC 449.2749 for the resident who is the subject of the report. (c) Make and maintain a report of any actions that are taken by the caregivers employed by the facility in response to a report submitted pursuant to paragraph (a). Inspector Comments: Based on record review, document review and interview, the facility failed to ensure a six month medication profile review was completed by the physician for 1 of 4 residents (Resident #4). Findings include: Resident #4 Resident #4 was admitted to the facility on 05/04/19, with diagnoses including hypertension, lung nodule and chronic kidney disease. Resident #4's clinical record had a six month medication review dated 05/30/20 and 03/16/21. On 08/26/21 at 9:02 AM, the Owner confirmed Resident #4 did not have a medication review between the dates of 05/30/20 and 03/16/21, and verbalized medication reviews were to be completed every six months. Severity: 2 Scope: 1	0870	Reminders will be posted to make sure we don't skip reviews anymore. Checking back with the Pharmacy or Physician will be made to make sure we get the signed form on time. Pharmacy review during the time of survey (Aug 25,2021) was March 16,2021. Next Pharmacy Review was done September 12, 2021 and will be followed every 6 months thereafter.	10/28/2021