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 _____	07/23/2025

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

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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 07/23/2025. 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 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 five. Five resident records and four 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 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		
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, 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	0878	The Manager/Caregiver has to check to make sure that the MAR in the facility matches what is in the Medication List of the VA and Hospice no matter what. If VA and Hospice make any changes/errors even without prior notice, it is still the DUTY and responsibility of the caregiver/med tech to check if there are changes made. Caregivers have to make sure what is given to the resident is the right dose.	08/08/2025

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	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 clinical record review and interview, the Administrator failed to ensure a resident received medications as prescribed for 1 of 5 residents (Resident #3). Findings include: Resident #3 Resident #3 was admitted to the facility on 05/28/2024, with diagnoses including chronic arthritis, dementia, and age-related debility. On 07/23/2025 at 12:16 PM, the following medication was found in Resident #3's medication bin and labeled as: -Acetaminophen 500 milligrams (mg), one tablet by mouth three times daily as needed for pain. Resident #3's Physician Order dated 05/20/2025, documented the following: -Acetaminophen 500 mg, 1 caplet by mouth three times a day as needed for pain. Resident #3's Medication Administration Record (MAR) dated July 2025, documented the following: -Acetaminophen 500 mg tablet, 500 mg by mouth three times a day for pain. The MAR			

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	documented Resident #3 received the medication three times daily from 07/01/2025 through 07/22/2025. The May and June 2025 MARs also documented the medication as administered three times daily for both months. On 07/23/2025 at 12:16 PM, the Caregiver/Manager (CG) verbalized the CG had not noticed the medication had changed from scheduled to as needed. The CG confirmed administering Resident #3 the medication three times daily since 05/20/2025. The CG verbalized the resident had not been administered the medication as prescribed and the MAR was incorrect. Severity: 2 Scope: 1			
1700 SS= F	Annual Assessment of History of Each Resident - NRS 449.1845 Administrator of residential facility for groups to conduct annual assessment of history of each resident and cause provider of health care to conduct certain examinations and assessments; placement based on assessment. 1. The administrator of a residential facility for groups shall: (a) Annually cause a qualified provider of health care to conduct a physical examination of each resident of the facility; (b) Annually conduct an assessment of the history of each resident of the facility, which must include, without limitation, an assessment of the condition and daily activities of the resident during the immediately preceding year; and (c) Cause a qualified provider of health care to conduct an assessment of the condition and needs of a resident of the facility to determine whether the resident meets the criteria prescribed in paragraph (a) of subsection 2: (1) Upon admission of the resident to the facility; and (2) If a physical examination, assessment of the history of the resident or the observations of the administrator or staff of the facility, the family of the resident or another person who has a relationship with the resident indicate that: (I) The resident may meet those criteria; or (II) The condition of the resident has significantly changed. 2. If, as a result of an assessment conducted pursuant to paragraph (c) of subsection 1, the provider of health care determines that the resident:	1700	Administrator/Manager/Caregiver from now on will make sure that ALL Physician Placement Determination and Standard Physician Assessments and Standard Assessment for Cognitive Abilities have to be done annually to monitor if there are any changes in the residents' care for proper placement.	08/08/2025

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	(a) Suffers from dementia to an extent that the resident may be a danger to himself or herself or others if the resident is not placed in a secure unit or a facility that assigns not less than one staff member for every six residents, any residential facility for groups in which the resident is placed must meet the requirements prescribed by the Board pursuant to subsection 2 of NRS 449.0302 for the licensing and operation of residential facilities for groups which provide care to persons with Alzheimer's disease or other severe dementia. (b) Does not suffer from dementia as described in paragraph (a), the resident may be placed in any residential facility for groups. 3. As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031. (Added to NRS by 2019, 2594) Inspector Comments: Based on clinical record review and interview, the Administrator failed to obtain an annual Standard Physician Assessment and Placement Determinations for 4 of 5 residents with a diagnosis of dementia (Resident #1. #2, #3, and #5). Findings include: Resident #1 Resident #1 was admitted to the facility on 09/23/2023, with diagnoses including cerebral infarction and dementia. Resident #1's record included a Standard Placement Determination dated 08/29/2023. The record lacked documented evidence of an annual Standard Placement Determination for 2024. Resident #2 Resident #2 was admitted to the facility on 12/15/2023, with diagnoses including cerebral atrophy and dementia. Resident #2's record included a Standard Placement Determination dated 12/14/2023. The record lacked documented evidence of an annual Standard Placement Determination for 2024. Resident #3 Resident #3 was admitted to the facility on 05/28/2024, with diagnoses including chronic arthritis and dementia. Resident #3's record included a Standard Placement Determination dated 05/13/2024. The record lacked documented evidence of an annual Standard Placement Determination for 2025. Resident #4 Resident #4 was admitted to the facility on 02/01/2022, with diagnoses including cerebrovascular accident and dementia.			

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	Resident #4's record included a Standard Placement Determination dated 07/18/2023. The record lacked documented evidence of an annual Standard Placement Determination for 2024 and 2025. On 07/23/2025 at 11:17 AM, the Caregiver/Owner (CG) confirmed a Standard Physician Assessment and Placement Determination had not been completed for Resident #1, #2, and #4 for 2024, and Resident #3 and #4 for 2025. The CG verbalized not knowing the document had to be completed annually for residents with a dementia diagnosis. Severity: 2 Scope: 3			