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 _____	07/05/2022

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 07/05/22. 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 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 files and four employee files were reviewed. The facility received a grade of D. NAC 449.27706 Resurvey: Application and fee; failure to comply. 2. If the Bureau issues a placard to a residential facility that includes a grade of "C" or "D," the administrator must submit an application to the Bureau for a resurvey of the facility not later than 30 days after the facility receives the placard. The fee for an application for a resurvey is $600 and must accompany the application. 3. The Bureau may revoke the license of a residential facility that is required to submit an application for a resurvey pursuant to subsection 2 if the facility fails to submit the application in accordance with the provisions of that subsection. 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: 08/29/2022

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0026 SS= D	Contents of License - Multiple Types - NAC 449.190 License: Contents; issuance of more than one type. 3. A residential facility may be licensed as more than one type of residential facility if the facility provides evidence satisfactory to the Bureau that it complies with the requirements for each type of facility and can demonstrate that the residents will be protected and receive necessary care and services. Inspector Comments: Based on clinical record review and interview, the facility failed to obtain an endorsement for Mental Illness (MI) and admitted and retained a resident with a MI diagnosis (Resident #4). Findings include: Resident #4 Resident #4 was admitted to the facility on 08/01/19, with a diagnosis of schizoaffective disorder and recurrent major depressive disorder. A History and Physical dated 08/19/21, documented Resident #4 had a diagnosis of schizoaffective disorder on 02/10/20. The facility lacked an MI endorsement to admit and retain residents with MI. On 07/05/22 at 10:42 AM, the Owner confirmed the facility was not endorsed for MI. Severity: 2 Scope: 1	0026	UPON ASSESSING A NEW RESIDENT AND BEFORE ADMISSION, WE HAVE TO CHECK THE DIAGNOSIS IF WE ARE ABLE TO ADMIT OR NOT TO ENSURE THE DEFICIENT PRACTICE DOES NOT RECUR. A RESIDENT WITH MI DIAGNOSIS WILL ONLY BE ADMITTED SHOULD OUR FACILITY APPLY FOR AND BE APPROVED BY THE STATE FOR MI ENDORSEMENT. DIAGNOSIS WILL BE REVIEWED BY EMPLOYEE #1 AND #2 TO MAKE SURE NO ONE WITH MI DIAGNOSIS WILL BE ACCEPTED UNTIL OTHERWISE MI ENDORSEMENT IS ACQUIRED. EMPLOYEE #1 AND #2 WILL BE RESPONSIBLE FOR ENSURING THE PLAN OF CORRECTION IS IMPLEMEMNTED. CORRECTIVE ACTION WAS COMPLETED AUGUST 1, 2022. RESIDENT #4 MOVED TO ANOTHER FACILITY.	08/29/2022

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0276 SS= D	Service of Food-Nutritious Meals;Frequency - NAC 449.2175 Service of food 7. Meals must be nutritious, served in an appropriate manner, suitable for the residents and prepared with regard for individual preferences and religious requirements. At least three meals a day must be served at regular intervals. The times at which meals will be served must be posted. Not more than 14 hours may elapse between the meal in the evening and breakfast the next day. Snacks must be made available between meals for the residents who are not prohibited by their physicians from eating between meals. Inspector Comments: Based on observation and interview the facility failed to ensure outdated perishable foods were discarded. Findings include: On 07/05/22 at 10:00 AM, a 12 ounce Classic Premium Cooked Ham, with an expiration date of 05/20/22 was found in the refrigerator for resident consumption. On 07/06/22 at 10:27 AM, the Owner confirmed the expired food items and verbalized it should have been discarded. Severity: 2 Scope: 1	0276	ALL FOODS WILL BE CHECKED FOR EXPIRATION DATES. OUTDATED PERISHABLE FOODS WILL BE DISCARDED ON A DAILY BASIS TO ENSURE THE DEFICIENT PRATICE DOES NOT RECUR. DAILY MONITORING OF EXPIRATION DATES WILL BE DONE AT THE BEGINNING OF EACH SHIFT EVERYDAY TO ENSURE THE DEFICIENT PRACTICE DOES NOT RECUR. EMPLOYEE #2, #3, AND #4 WILL ALL BE RESPONSIBLE FOR DAILY MONITORING DEPENDING ON WHO IS ON THE SCHEDULE. EMPLOYEE #2 WILL BE RESPONSIBLE FOR ENSURING THE PLAN OF CORRECTION IS IMPLEMENTED. CORRECTIVE ACTION STARTED JULY 6, 2022.	08/29/2022

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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. Inspector Comments: Based on observation and interview, the facility failed to maintain the contents of a first aid kit required by Nevada Administrative Code 449.231(2)(a-f). Findings include: On 07/05/22, a review of the facility's first aid kit included two bottles of wound cleanser with an expiration date of 07/21 and 11/2019. The kit lacked a germicide safe for humans. On 07/05/22 at 10:17 AM, the owner confirmed the wound cleanser in the first aid kit was expired and lacked a germicide safe for humans. Severity: 2 Scope: 1	0451	FIRST AID KIT ITEMS WILL BE MAINTAINED DAILY. OUTDATED ITEMS WILL BE DISCARDED ON A DAILY BASIS TO MAKE SURE THIS DEFICIENT PRACTICE DOES NOT RECUR. TO MAKE SURE FIRST AID KIT ITEMS ARE ALL CURRENT, WHEN MONITORING EXPIRATION DATES, THOSE CLOSE TO EXPIRING WILL BE SEPARATED AND PLACED IN FRONT OF ALL THE OTHER ITEMS TO AVOID OVERLOOKING AND FORGETTING EXPIRATION DATES. EMPLOYEE #2 WILL BE RESPONSIBLE TO ENSURE THE PLAN OF CORRECTION IS IMPLEMENTED. CORRECTIVE ACTION STARTED JULY 6, 2022.	08/29/2022

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0515 SS= F	Supervision and Treatment of Residents - NAC 449.259 Supervision and treatment of residents generally. (NRS 449.0302) 1. A residential facility shall: (a) Provide each resident with protective supervision as necessary; (b) Inform all caregivers of the required supervision; Inspector Comments: Based on observation and interview, the facility failed to provide protective supervision for 5 of 5 residents (Residents #1, #2, #3, #4, and #5). Findings include: On 07/05/22 at 8:50 AM, State Surveyors entered the facility. The person that answered the door verbalized they were not a caregiver and the Owner had left the facility to take a resident to an appointment. The person explained they came to help while the Owners were out confirmed there was no caregiver on site. On 07/05/22 at 9:00 AM, Owner #1 arrived at the facility and verbalized Owner #1 had left the facility to go take a shower. Owner #1 explained Owner #2 had been at the facility when Owner #1 left to take a shower. Owner #1 verbalized the person that answered the door was not an employee of the facility and had not received a background check or caregiver training. Owner #1 admitted the Owners should not have left the facility without a caregiver present to provide supervision to the residents in the facility. On 07/05/22 at 9:10 AM, Owner #2 arrived at the facility. Owner #2 verbalized the Owner had left the facility to take a resident from another facility to a doctor appointment. The Owner admitted the person that answered the door was not an employee, did not have a background check, and had not completed any caregiver training. Owner #2 confirmed five residents were left in the facility without a trained caregiver. The Owner explained it was not appropriate to leave residents in the facility without a trained caregiver because an untrained person may not know how to deal with a dangerous situation. Severity: 2 Scope: 3	0515	A QUALIFIED/TRAINED CAREGIVER WILL BE ON-SITE AT ALL TIMES. THERE WILL BE NO EXCUSE TO LEAVE THE FACILITY WITHOUT A QUALIFIED/TRAINED CAREGIVER ON SITE TO ENSURE THE DEFICIENT PRACTICE DOES NOT RECUR. BEFORE LEAVING THE FACILITY, BETWEEN EMPLOYEE #2, #3, AND/OR #4, WE WILL MAKE SURE ONE OF US WILL BE ON-SITE TO ENSURE THE DEFICIENT PRACTICE DOES NOT RECUR. EMPLOYEE #2 AND #3 WILL BE RESPONSIBLE TO ENSURE THE PLAN OF CORRECTION IS IMPLEMENTED. CORRECTIVE ACTION STARTED JULY 6, 2022.	08/29/2022

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0593 SS= F	Rights of Residents; Procedure for Filing - NAC 449.268 Rights of residents; procedure for filing grievance, complaint or report of incident; investigation and response. (NRS 449.0302) 1. The administrator of a residential facility shall ensure that: (d) The facility is a safe and comfortable environment; Inspector Comments: Based on observation and interview, the Administrator failed to ensure a safe environment for 5 of 5 residents by not ensuring visitors to the facility were screened for temperature and signs and symptoms of COVID-19 (COVID). Findings include: On 07/05/22 at 8:50 AM, upon entry to the facility, the State Surveyors were not screened for temperature and signs and symptoms of COVID. On 07/05/22 at 9:05 AM, the Owner confirmed the State Surveyors should have been screened for temperature and signs and symptoms of COVID-19 upon entrance to the facility. The Infection Prevention and Control Plan for Residential Facilities Coronavirus Disease 2019 (COVID-19) Response Best Practices dated September 20, 2021, and distributed by the State of Nevada Bureau of Health Care Quality and Compliance to all Residential Facilities for Groups on 10/12/21, documented designate one or more facility employees to actively screen all visitors and personnel, including essential consultant personnel, for the presence of fever and symptoms of COVID-19 before starting each shift/when they enter the building. Severity: 2 Scope: 3	0593	ALL VISITORS AND PERSONNEL WILL BE SCREENED UPON ENTRY TO THE FACILITY FOR THE PRESENCE OF FEVER AND SIGNS AND SYMPTOMS OF COVID-19. UPON ENTRY OF VISITORS, PERSONNEL AND ESSENTIAL CONSULTANT PERSONNEL, A DESIGNATED EMPLOYEE WILL SCREEN FOR FEVER AND SYMPTOMS OF COVID 19 BEFORE STARTING A SHIFT OR VISIT WITH OUR RESIDENTS TO ENSURE THE DEFICIENT PRACTICE DOES NOT RECUR. EMPLOYEE #2 WILL BE RESPONSIBLE OF ENSURING THAT THE PLAN OF CORRECTION IS IMPLEMENTED. CORRECTIVE ACTION STARTED JULY 6, 2022.	08/29/2022

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0620 SS= D	Written Policy on Admissions - NAC 449.2702 Written policy on admissions; eligibility for residency. (NRS 449.0302) 4. Except as otherwise provided in NAC 449.275 and 449.2754, a residential facility shall not admit or allow to remain in the facility any person who: (a) Is bedfast; (b) Requires restraint; (c) Requires confinement in locked quarters; or (d) Requires skilled nursing or other medical supervision on a 24-hour basis. Inspector Comments: Based on observation, clinical record review, and interview, the facility failed to obtain an exemption request to retain a bedfast resident for 1 of 5 residents (Resident #2). Findings include: Resident #2 Resident #2 was admitted to the facility on 05/29/17, with diagnoses including dementia, cerebral atherosclerosis, and sequela of cerebrovascular accident. A Physician Initial Certification of Terminal Illness dated 11/05/20, documented Resident #2 was bedbound due to contracted bilateral upper and lower extremities, and unable to hold body up without support. An Interdisciplinary Group Plan of Care Update Report for Resident #2 dated 06/07/22, documented the resident was bedbound. Resident #2's clinical record lacked documented evidence an exemption request was submitted to the State of Nevada to retain a bedbound resident. On 07/05/22 at 9:56 AM, the Owner verbalized Resident #2 was bedbound and not able to turn or change position without the help of a caregiver. The Administrator confirmed an exemption request was not submitted to the State of Nevada to retain a bedbound resident. Severity: 2 Scope: 1	0620	FUTURE RESIDENT ADMISSIONS OR IF A CURRENT RESIDENT CHANGES LEVEL OF CARE, MEDICAL CONDITION AND/OR BECOME BEDFAST, WE WILL MAKE SURE TO ACQUIRE AN EXEMPTION REQUEST TO ADMIT OR RETAIN A BEDBOUND RESIDENT TO ENSURE THE DEFICIENT PRACTICE DOES NOT RECUR. A THOROUGH CHECK OF THE ASSESSMENT FROM THE DOCTOR IF ADMITTING OR REASSESSMENT OF A CURRENT RESIDENT THAT BECOMES BEDFAST, A BEDFAST EXEMPTION WILL BE APPLIED IMMEDIATELY TO ENSURE THE DEFICIENT PRACTICE DOES NOT RECUR. EMPLOYEE #1 AND #2 WILL BE RESPONSIBLE FOR ENSURING THE PLAN OF CORRECTION IS IMPLEMENTED. APPLICATION FOR BEDFAST WAIVER FOR RESIDENT #2 WAS SUBMITTED ONLINE ON AUGUST 15,2022 AND APPROVED AUGUST 22,2022. CORRECTIVE ACTION WAS COMPLETED AUGUST 22, 2022.	08/29/2022

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0938 SS= E	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. Inspector Comments: Based on clinical record review and interview, the facility failed to ensure an initial Activities of Daily Living (ADL's) assessment was completed at or prior to admission for 2 of 5 residents (Resident #1, and #5). Findings include: Resident #1 Resident #1 was admitted to the facility on 02/01/22, with diagnoses including congestive heart failure and bilateral lower extremity edema. Resident #1's clinical record documented an initial ADL assessment was completed on 02/05/22, four days after the date of admission. Resident #5 Resident #5 was admitted to the facility on 02/11/22, with diagnoses including dementia, anxiety, and osteoarthritis. Resident #5's clinical record documented an initial ADL assessment was completed on 02/15/22, four days after the date of admission. On 07/05/22 at 11:00 AM, the Owner confirmed the ADL assessment was completed after admission for Resident #1 and #5. Severity: 2 Scope: 2	0938	ALL FUTURE RESIDENT ADMISSIONS WILL ALL HAVE THEIR ADL ASSESSMENT DONE ON THE VERY FIRST DAY TO ENSURE THE DEFICIENT PRACTICE DOES NOT RECUR. AS SOON AS A RESIDENT IS ADMITTED TO THE FACILITY, EMPLOYEE #2 AND/OR #3 WILL RIGHT AWAY FILL OUT THE FORM OF THE ADL ASSESSMENT TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR. EMPLOYEE #2 WILL BE RESPONSIBLE FOR ENSURING THE PLAN OF CORRECTION IS IMPLEMENTED. CORRECTIVE ACTION WAS COMPLETED JULY 5, 2022.	08/29/2022

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1550 SS= F	The facility shall keep documentation in the Inspector Comments: Based on interview the facility failed to submit to the Division of Public and Behavioral Health a cultural competency course/training program or provide documented evidence of a contract with a third party, to develop and operate the program for cultural competency for employee training. Findings include: On 7/05/22 at 11:52 AM, the Owner acknowledged there was no cultural competency training program implemented for the employees. Severity: 2 Scope: 3	1550	NEW EMPLOYEES WILL BE REQUIRED TO TAKE THE CULTURAL COMPETENCY TRAINING WITHIN 30 DAYS OF EMPLOYMENT. EMPLOYEE #2, #3, AND #4 HAVE COMPLETED THE CULTURAL COMPETENCY MANDATORY TRAINING AND WILL CONTINUE TO COMPLY WITH COMPLETING AND ANNUALLY RENEWING THIS REQUIREMENT TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR. LIKE ALL OTHER ANNUAL REQUIREMENTS, CULTURAL COMPETENCY TRAINING WILL BE ON THE CALENDAR FOR EMPLOYEE #2 TO MONITOR TO ENSURE THE DEFICIENT PRACTICE DOES NOT RECUR. EMPLOYEE #1 AND #2 WILL MAKE SURE THAT THESE REQUIREMENTS WILL BE DONE IN A TIMELY MANNER TO ENSURE THE PLAN OF CORRECTIONMIS IMPLEMENTED. EMPLOYEE #2, #3, AND #4 HAVE COMPLETED THE CULTURAL COMPETENCY MANDATORY TRAINING. CORRECTIVE ACTION WERE COMPLETED JULY 8,2022, JULY 8,2022 AND JULY 18,2022 RESPECTIVELY.	08/29/2022

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1700 SS= E	Annual Assessment of History of Each Resident Inspector Comments: Based on interview and record review, the Administrator failed to ensure a resident with a diagnosis of dementia had a standard placement determination completed by a provider prior to admission to the facility to ensure the facility would have been able to provide the appropriate level of care in 2 of 5 residents (Resident #2 and #5). Findings include: Resident #2 Resident #2 was admitted to the facility on 05/29/17, with a diagnosis of dementia. A History and Physical dated 08/20/20, documented Resident #2 had a diagnosis of dementia. The clinical record for Resident #2 lacked a completed standard placement determination. Resident #5 Resident #5 was admitted to the facility on 02/11/22, with diagnoses including dementia, anxiety, and osteoarthritis. A History and Physical dated 02/16/22, documented Resident #5 had a diagnosis of dementia. The clinical record for Resident #5 lacked a completed standard placement determination. On 07/05/22 at 10:25 AM, the Owner confirmed Residents #2 and #5 had diagnoses of dementia and the standard placement determination had not been completed for the residents. Severity: 2 Scope: 2	1700	FUTURE RESIDENT ADMISSION WITH A DIAGNOSIS OF DEMENTIA OR IF A CURRENT RESIDENT WILL LATER BE DIAGNOSED WITH DEMENTIA, A STANDARD PLACEMENT FORM WILL BE ACQUIRED FROM THE PHYSICIAN TO COMPLY WITH THE REQUIREMENT TO ENSURE THE DEFICIENT PRACTICE DOES NOT RECUR. EMPLOYEE #2 WILL MONITOR DIAGNOSIS OF RESIDENTS WITH DEMENTIA FOR NEW ADMISSION OR FOR CURRENT RESIDENTS TO BE ABLE TO ACQUIRE PROPER DOCUMENTATION FROM THE PHYSICIAN TO ENSURE THE DEFICIENT PRACTICE DOES NOT RECUR. EMPLOYEE #1 AND #2 WILL BE RESPONSIBLE FOR ENSURING THE PLAN OF CORRECTION IS IMPLEMENTED. CORRECTIVE ACTION WAS COMPLETED JULY 7,2022.	08/29/2022