

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3275	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/01/2020
NAME OF PROVIDER OR SUPPLIER EVERGREEN RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 1305 KINGS COURT, RENO, NEVADA ,89503		
(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 the result of a State Licensure COVID-19 Focused Infection Control Survey conducted in your facility on 12/01/20. 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 eight Residential Facility for Group beds for elderly and disabled persons and/or persons with mental illness and/or persons with chronic illness and/or persons with intellectual disabilities, three Category I and five Category II residents. The census at the time of the survey was 5. There were four positive COVID-19 asymptomatic residents and two positive COVID-19 asymptomatic staff in the facility at the time of the survey. This infection control survey was the result of four positive residents and three positive staff. The investigation of regulatory compliance Infection Control and Prevention included: - Visitor entry and facility screening practices; - Education, monitoring, and screening practices of staff; - Emergency staffing plan; - Infection control practices; - Personal Protective Equipment (PPE) inventory; and - Observation of staff wearing masks, face shields, and gowns. Residents were remaining in their rooms. Interviews were conducted with the Owner, Caregiver and Administrator via telephone. The findings and conclusions of any investigation by the Health Division 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. No 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER Name: _____ Title: _____ Date: _____
REPRESENTATIVE'S SIGNATURE