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 _____	**09/22/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN RESIDENCE	**1305 KINGS COURT, RENO, NEVADA ,89503**

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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 and complaint investigation conducted at your facility on 09/22/22. This survey was conducted by the Division of Public and Behavioral Health in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility was licensed for eight Residential Facility for Group beds for elderly and disabled persons, three Category I and five Category II residents. The census at the time of survey was seven . Seven resident files were reviewed and four employee files were reviewed. The facility received a grade of C. 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. There were two complaints investigated: Complaint #NV00066587 could not be substantiated. The allegation of misappropriation of property could not be substantiated. The investigation into the allegation included; Observations of residents and a brief tour of the facility. Interviews were conducted with the caregiver and the Administrator. 7 resident files were reviewed, including the residents of concern. Complaint #NV00065950 was substantiated (see tag Y0920). The allegation of unsecured medication and medication self administration was substantiated. The findings and conclusions	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: LAILA BUENVIAJE Title: Administrator Date: 10/23/2022

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	of any investigation by the Division of Public and Behavioral Health 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. The following regulatory deficiencies were identified:			
0102 SS= D	Personnel File - TB Screening - NAC 449.200 Personnel files. 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (d) The health certificates required pursuant to chapter 441A of NAC for the employee; Inspector Comments: Based on record review, document review, and interview, the facility failed to ensure an employee met the requirements concerning tuberculosis (TB) testing for 1 of 4 employees (Employee #3). Findings include: Employee #3 Employee #3 was hired as a caregiver 08/29/22. Employee #3 had a positive TB QuantiFERON test on 06/10/22 and an x-ray completed on 06/10/22. The employee's filed lacked evidence of a completed signs and symptoms questionnaire completed at the time of hire. On 09/22/22 at 11:07 AM, the Caregiver confirmed Employee #3 did not have a signs and symptoms questionnaire completed, Employee #3 had been working with residents and the signs and symptoms questionnaire was required to be completed at the time of hire. The Caregiver verbalized it was important to screen employee for signs and symptoms of TB upon hire and annually thereafter, especially if the employee had a positive test. The Caregiver explained it was important to keep residents safe. Severity: 2 Scope: 1	0102	Caregiver has TB S&S in her file but the date was not written down. Surveyor said that since it did not have a date, they don't know when it was done. TB S & S was done but the date was not filled up. Administrator filled up the form and put in the employees file after the Quantiferon test and Chest X-ray were done prior to hire date. We will make sure that it is completely filled up when placed in the employee's binder. 1. We will make sure that newly hired employees should have a completely filled up tb s&s including the date, before hire date. 2. Before the start of hire date, employee's file should be checked for completeness. 3. The new employee file will be double checked for completeness prior to start date. 4. Owner and Administrator. 5. On the date of survey., 09/22/22	09/22/2022

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0178 SS= D	Health & Sanitation - Maintain Int/ext - NAC 449.209 Health and sanitation. (NRS 449.0302) 5. The administrator of a residential facility shall ensure that the premises are clean and that the interior, exterior and landscaping of the facility are well maintained. Inspector Comments: Based on observation and interview, the facility failed to ensure trash was in an enclosed container in the backyard. Findings include: On 09/22/22 at 10:07 AM, in the backyard were two trash bins and two recycle bins, however eight bags of trash were up against the fence in a pile. On 09/22/22 at 10:15 AM, the Caregiver confirmed there were eight bags of trash against the fence and not in a closed trash container. The Caregiver verbalized the containers were not full and did not know why the trash was not placed inside the transh containers. Severity: 2 Scope: 1	0178	The employee was collecting the recycle trash that's the reason it was piled in plastics outside. Employee will not collect the recycle trash anymore. 1. The trashes in the back are cleaned and placed in the trash can. 2. Caregivers will make sure that trashes will be put inside the trash can every time there are trashes. 3. Every night the caregiver will check the trashes in the back and make sure all are inside the trash can. 4. Caregiver 5. 09/22/22	10/22/2022

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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, interview, and record review, the facility failed to provide a safe environment for residents by not ensuring staff correctly wore personal protective equipment (PPE). Findings include: On 09/22/22 at 9:26 AM, upon entry into the facility, Caregiver #1 answered the door and was not wearing a mask. A second Caregiver #2 was walking from the hallway into a common area and was not wearing a mask. On 09/22/22 at 9:27 AM, Caregiver #1 confirmed staff were not wearing masks and verbalized all staff were to be wearing a mask at all time to keep residents safe from a possible COVID-19 outbreak. Severity: 2 Scope: 3	0593	Retraining was provided to make sure all staff are wearing mask even if they are vaccinated with covid 19 and with booster. A signage for wearing a mass is hang on the wall at the facility to remind caregivers all the time. 1. We will make sure that all staffs are wearing mask when on duty. 2. We will have a signage hung on the wall in the facility, to remind employees to wear their mask. 3. Owner will check if employees are complying everyday. 4. Owner. 5. 09/22/22 staff put mask on, retraining done on 09/24/22	09/22/2022

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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 ensure a bedfast resident was not retained or admitted to the facility for 1 of 7 residents (Resident #6). Findings include: Resident #6 Resident #6 was admitted to the facility on 08/20/22, with a diagnosis of physical debility. On 09/22/22 at 9:27 AM, a Caregiver explained Resident #6 was bedbound, meaning the resident could not turn, nor move independently on their own in bed. The resident needed extensive assistance and the caregivers were responsible for repositioning the resident, if needed. On 09/22/22 at 9:33 AM, Resident #6 explained not being able to turn on their own and depended on staff to get the resident out of bed if needed. The Resident verbalized staff would come in periodically to adjust the resident. Resident #6 verbalized not being able to move or do any activity on their own. On 09/22/22 at 9:40 AM, the Caregiver confirmed Resident ##6 did not have a bedfast waiver and an exemption request was not submitted to the State of Nevada to retain a bedbound resident. Severity: 2 Scope: 1	0620	Patient's Bedfast Waiver Exemption was submitted on 08/28/22 after receiving the Homehealth plan of care for Physical therapy and Nursing. It was followed up on 09/22/22. Received bedfast approval on 09/30/22. 1. Ensure that patient's bedfast waiver application was approved to retain or admit resident in the facility. 2. Apply exemption waiver on the discovery date that patient is found to be bedfast and follow up until the bedfast exemption waiver is received. 3. Monitor all the residents monthly if there will be a candidate that needs bedfast for retention. 5. Owner and Administrator. 6. Bedfast waiver exemption was submitted on 08/28/22, followed up on 09/22/22. Bedfast approval received on 09/30/22.	08/28/2022
0876 SS= E	Medication Administration - NRS 449.0302 - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. (as amended by LCB File No. R109-18) 4. Except as otherwise provided in this subsection, a caregiver shall assist in the	0876	1. We will ensure that Ultimate user agreement is properly filled up, correct box is checked, correct date is written. 2. We will check resident's Ultimate User Agreement for completeness before placing in the resident's file. 3. The Ultimate User Agreement will be	09/22/2022

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	administration of medication to a resident if the resident needs the caregiver's assistance. A caregiver may assist the ultimate user of: (a) Controlled substances or dangerous drugs only if the conditions prescribed in subsection 6 of NRS 449.0302 are met. (b) Insulin using an auto-injection device only if the conditions prescribed in NRS 449.0304 and section 13 of this regulation are met. Inspector Comments: Based on clinical record review and interview, the facility failed to ensure an ultimate user agreement was completed for 3 of 7 sampled residents (Residents #3, #4 and #6). Findings include: Resident #3 Resident #3 was admitted on 08/18/22, with a diagnosis including Healthcare-associated pneumonia. Resident #3's clinical record contained an invalid Ultimate User Agreement as both boxes were selected, On 09/22/22 at 1:19 PM, the Caregiver confirmed Resident #3's clinical record contained an invalid Ultimate User Agreement with both boxes selected. The Caregiver confirmed the facility administered medications to Resident #3. Resident #4 Resident #4 was admitted to the facility on 08/28/22, with a diagnosis of memory concerns. Resident #4's clinical record contained an Ultimate User Agreement dated 09/01/22, four days after the resident's admission. On 09/22/22 at 1:25 PM, the Caregiver confirmed Resident #4's Ultimate User Agreement was dated and signed four days after the resident's admission. The Caregiver confirmed the facility administered medications to Resident #4 on the day of admission. Resident #6 Resident #6 was admitted to the facility on 08/20/22, with a diagnosis of physical debility. Resident #6's clinical record contained an Ultimate User Agreement; however, the document was not dated. On 09/22/22 at 12:31 PM, the Caregiver confirmed Resident #6's Ultimate User Agreement was not dated. The Manager confirmed the facility administered		checked prior to filing the residents file in the binder and after filing, to ensure it is properly filled up. 4. Owner and Administrator. 5.09/22/22 Comment: Resident #3 is on hospice and can not take care of her own medication. Ultimate User Agreement was corrected with one box checked only. Resident #4 has a user Ultimate Use Agreement signed on 09/01/22 which is the move in date of the patient to the facility. Caregiver mistakenly put the admission date as 8/28/22, which was the date the daughter paid and reserved the bed for the patient. Daughter is aware that her mother can not move in until all requirements done. This date in the user agreement is correct. Resident #6 Has signed Ultimate user agreement. The signed form was faxed by Renown on 08/20/22, the date patient signed it prior to admission. The faxed date is on the upper page of the form. Date was written down on the form. *COMMENT: The deficiency should be wrong admission date for Resident #4. The Ultimate User Agreement was signed on 09/01/22. Patient moved to the facility on 09/01/22 and not on 08/28/22 as explained above The Administrator is requesting to please update TAG 0876 with the correct citation and scope and severity. Please see attached administrative review request.*	

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	medications to Resident #6. Severity: 2 Scope: 2			
0920 SS= D	Medication: Storage - NAC 449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. (NRS 449.0302) 1. Medication, including, without limitation, any over-the-counter medication, stored at a residential facility must be stored in a locked area that is cool and dry. The caregivers employed by the facility shall ensure that any medication or medical or diagnostic equipment that may be misused or appropriated by a resident or any other unauthorized person is protected. Medications for external use only must be kept in a locked area separate from other medications. A resident who is capable of administering medication to himself or herself without supervision may keep the resident ' s medication in his or her room if the medication is kept in a locked container for which the facility has been provided a key. 2. Medication stored in a refrigerator, including, without limitation, any over-the-counter medication, must be kept in a locked box unless the refrigerator is locked or is located in a locked room. Inspector Comments: Based on interview, observation, and clinical record review, the facility failed to ensure self-administered medications were secure for 1 of 7 residents (Resident #3). Findings include: Resident #3 Resident #3 was admitted to the facility on 08/18/22, with a diagnosis of healthcare associated pneumonia. On 09/22/22 at 9:41 AM, located in the refrigerator were two syringes of haloperidol. The syringes were to be used orally and were pre-drawn by the pharmacy. Resident #3's physician order dated 09/04/22, documented haloperidol lactate, 2 milligram (mg)/milliliter (ml) concentrate. Administer 1 ml orally, two times a day for anxiety. On 09/22/22 at 9:41 AM, the Caregiver confirmed the medication was left unsecured and verbalized all medications were to be locked at all times to prevent residents from	0920	The Haldol was supposed to be given to the resident, however the resident was still sleeping so the caregiver placed the Haldol back in the refrigerator. The Caregiver did not leave the medication in the bedside.The caregiver inadvertently placed the medication in the refrigerator and not in the lock box inside the refrigerator. Retraining was provided for the caregivers. Employee # 3 not with the facility anymore. 1. We will make sure that the medication not administered yet be placed back in the lock container. 2. Caregiver was retrained for proper handling of medications and proper storage. 3. Caregiver will be regularly reminded of proper medication handling and storage. 4. Owner, Administrator 5. 09/22/22	09/22/2022

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	ingesting medications not belonging to them. Severity: 2 Scope: 1 Complaint #NV00065950			
0930 SS= F	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: (a) The full name, address, date of birth and social security number of the resident. (b) The address and telephone number of the resident ' s physician and the next of kin or guardian of the resident or any other person responsible for the resident. (c) A statement of the resident ' s allergies, if any, and any special diet or medication he or she requires. Inspector Comments: Based on observation, record review, and interview, the facility failed to ensure resident medical records were complete for 4 of 7 sampled residents (Residents #1, #3, #4, and #6). Findings include: Resident #1 Resident #1 was admitted to the facility on 04/27/22, with a diagnosis including diabetes mellitus. Resident #1's clinical record documented that an initial ADL assessment was completed but lacked a completion date. On 09/22/22 at 12:31 PM, the Caregiver confirmed the ADL assessment was not completed timely for Resident #1. Resident #3 Resident #3 was admitted to the facility on 08/18/22, with a diagnosis of healthcare-associated pneumonia. Resident #3's clinical record documented an initial ADL assessment completed on 08/19/22, one day after the assessment was due. Resident #3's clinical record contained an	0930	1. We will make sure that all required documents are filled up completely on a timely manner. 2. We will check that the forms are completely filled up, with the correct date. 3. We will double check the required forms before putting in the chart and after filing the forms for completeness. 4. Owner and Administrator. 5. 09/22/22 Comment: Resident #1 ADL was completed but no date. It was done on the day of admission staff missed putting the date. Resident # 3, Patient was admitted later in the afternoon after 5 pm on 08/18/22 and patient went to bed right away. ADL assessment was done the morning of next day. Patient was assessed in real time on 08/19/22. Resident #3 is on hospice and can not take care of her own medication. Ultimate User Agreement was corrected with one box checked only. Resident #6 Has signed Ultimate user agreement. The signed form was faxed by Renown on 08/20/22, the date patient signed it prior to admission. The faxed date is on the upper page of the form. Date was written down on the form. Resident #4, has an Ultimate User Agreement signed on 09/01/22, ADL assessment done on 09/01/22, Quantiferon TB screening test done on 08/29/22. Patient moved in to the facility on 09/01/22. Caregiver mistakenly put the admission date as 8/28/22, which was the date the daughter paid and reserved the bed for the patient. Daughter was aware that her mother can not move in to the	09/22/2022

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	invalid Ultimate User Agreement as both boxes were selected, On 09/22/22 at 1:19 PM, the Caregiver confirmed Resident #3's clinical record contained an invalid Ultimate User Agreement with both boxes selected. The Caregiver confirmed Resident #3's ADL assessment was completed late. Resident #4 Resident #4 was admitted to the facility on 08/28/22, with a diagnosis of memory concerns. Resident #4's clinical record documented an initial ADL assessment completed on 08/29/22, one day after the resident's admission. Resident #4's clinical record contained an Ultimate User Agreement dated 09/01/22, four days after the resident's admission. Resident #4's clinical record documented evidence of a QuantiFERON test conducted on 08/29/22, one day after the resident was admitted. On 09/20/22 at 10:31 AM, the Caregiver acknowledged the TB testing was late and not completed prior to or at the time of admission. On 09/22/22 at 1:25 PM, the Caregiver confirmed Resident #4's Ultimate User Agreement was dated and signed four days after the resident's admission. The Caregiver confirmed Resident #4's ADL assessment was completed one day after the resident's admission. Resident #6 Resident #6 was admitted to the facility on 08/20/22, with a diagnosis of physical debility. Resident #6's clinical record contained an Ultimate User Agreement; however, the document was not dated. On 09/22/22 at 12:31 PM, the Caregiver confirmed the ADL assessment was not completed timely for Resident #6. Severity: 2 Scope: 3		facility until all requirements are submitted in and waited until all requirements were done. The Ultimate User Agreement, ADL assessment, Quantiferon tb test were all done prior to admission on 09/01/22. Resident Front cover corrected . Admission date is 09/01/22 and not 08/28/22. *The deficiency should be wrong admission date for Resident #4. The Quantiferon TB test result was received on 08/31/22, ADL assessment was done on 09/01/22 and Ultimate User Agreement on 09/01/22. Patient moved to the facility on 09/01/22 and not on 08/28/22 as explained above. The Administrator is requesting to please update TAG 0930 with the correct citation and scope and severity. Please see attached* ***Administrative review request.***	

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0936 SS= D	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: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. Inspector Comments: Based on record review, document review, and interview, the facility failed to ensure 1 of 7 residents met the requirements for timely tuberculosis (TB) testing in accordance with Nevada Administrative Code (NAC) 441A (Resident #4). Findings include: Resident #4 Resident #4 was admitted on 08/28/22 with a diagnosis including memory concerns. Resident #4's clinical record documented evidence of a QuantiFERON test conducted 08/29/22, one day after the TB testing was due. On 09/20/22 at 10:31 AM, the Caregiver acknowledged the TB testing was late and not completed prior to or at time of admission. Severity: 2 Scope: 1	0936	1. We will make sure that accurate admission date will be put in the front cover of the chart. 2. We will double check the date we put in the admission date to make sure it is accurate. 3. Owner or Administrator will check the chart for completion upon admission to ensure accuracy of information in the chart. 4. Caregiver, Owner and Administrator 5. 09/22/22 COMMENT: The patient was admitted on 09/01/22 and not 08/28/22. We only accept resident once all necessary documents have been submitted. The daughter went to the facility and gave some documents and payment to reserve the bed on 08/28/22, thus the caregiver put as the date of admission. Patient moved to the facility on 09/01/22 . We waited until quantiferon tb test result on 08/31/22 was received. Front cover sheet updated with correct admission date. *The deficiency should be wrong admission date. The Quantiferon TB test result was received on 08/31/22. Patient moved to the facility on 09/01/22. The Administrator is requesting to please update TAG 0936 with the correct citation and scope and severity. Please see attached Administrative Review Request.*	09/22/2022
0938 SS= F	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	0938	Resident #1 ADL was completed but no date. It was done on the day of admission staff missed putting the date. Resident # 3, Patient was admitted later in the afternoon after 5 pm on 08/18/22 and patient went to bed right away. ADL assessment was done the morning of next day. Patient was assessed in real time on 08/19/22. Resident #3 is on	09/22/2022

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 _____	**09/22/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN RESIDENCE	**1305 KINGS COURT, RENO, NEVADA ,89503**

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	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 initial Activities of Daily Living (ADL) assessments were completed timely for 4 of 7 sampled residents (Resident #1, #3, #4, and #6). Findings include: Resident #1 Resident #1 was admitted to the facility on 04/27/22, with a diagnosis including diabetes mellitus. Resident #1's clinical record documented an initial ADL assessment was completed but lacked a completion date. Resident #3 Resident #3 was admitted to the facility on 08/18/22, with a diagnosis of healthcare-associated pneumonia. Resident #3's clinical record documented an initial ADL assessment completed on 08/19/22, one day after the assessment was due. Resident #4 Resident #4 was admitted to the facility on 08/28/22, with a diagnosis of memory concerns. Resident #4's clinical record documented an initial ADL assessment completed on 08/29/22, one day after the assessment was due. Resident #6 Resident #6 was admitted to the facility on 08/20/22, with a diagnosis of physical debility. Resident #6's clinical record lacked an initial ADL assessment. On 09/22/22 at 12:31 PM, the Caregiver confirmed the ADL assessments were not completed timely for Residents #1, #3 #4, and #6. Severity: 2 Scope: 3		hospice and can not take care of her own medication. Ultimate User Agreement was corrected with one box checked only. Resident #6 Has signed Ultimate user agreement. The signed form was faxed by Renown on 08/20/22, the date patient signed it prior to admission. The faxed date is on the upper page of the form. Date was written down on the form. Resident #4, has an Ultimate User Agreement signed on 09/01/22, ADL assessment done on 09/01/22, Quantiferon TB screening test done on 08/29/22. Patient moved in to the facility on 09/01/22. Caregiver mistakenly put the admission date as 8/28/22, which was the date the daughter paid and reserved the bed for the patient. Daughter was aware that her mother can not move in to the facility until all requirements are submitted in and waited until all requirements were done. The Ultimate User Agreement, ADL assessment, Quantiferon tb test were all done prior to admission on 09/01/22. Resident Front cover corrected . Admission date is 09/01/22 and not 08/28/22. 1. We will make sure that all required documents are filled up completely on a timely manner. 2. We will check that the forms are completely filled up, with the correct date. 3. We will double check the required forms before putting in the chart and after filing the forms for completeness. 4. Owner and Administrator. 5. 09/22/22 *COMMENT: According to the*	

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		A. BUILDING _____ B. WING _____	**09/22/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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			Interpretative Guidelines, the finding of the Inspector is doubled with TAG 0930. Both Maintenance and contents of separate files, with same findings as TAG 0930. This tag is a duplicate of TAG 0930. The Administrator is requesting to please null and void this TAG 0938. Please see attached Administrative review request.	