

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 A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2024
NAME OF PROVIDER OR SUPPLIER EVERGREEN RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 1305 KINGS COURT, RENO, NEVADA ,89503	
(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 complaint investigation survey conducted in your facility on 05/21/24. 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 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 7. Two resident files were reviewed. The facility received a grade of A. There was one complaint investigated: Complaint #NV00070353 with the allegation the facility admitted a resident with an inappropriate level of care could not be substantiated due to lack of sufficient evidence. The investigation into the allegation included: Interviews were conducted with a Caregiver, the Administrator, and the Owner-Caregiver. Review of two resident records including the resident of concern. Observations of residents in common areas, and staff and resident interactions. Document review of the facility's Care Agreement, facility Admission Agreement, Hospice notes, and documentation for a bedfast waiver. 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 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. No further action necessary. Please retain a copy for your records.	0000		

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

Title:

Date:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.