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 _____	**07/23/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN RESIDENCE	**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 07/23/2024. 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, three Category I and five Category II residents. The census at the time of survey was four. Four resident records, two discharged resident records and three employee records were reviewed. There were two complaints investigated. Complaint #NV00071646 with an allegation the facility's swamp cooler was not on and the temperatures within the facility reached 87 degrees Fahrenheit could not be substantiated due to a lack of evidence. Complaint #NV00071750 with the following allegations could not be substantiated due to a lack of evidence. Allegation #1: A Caregiver hit a resident in the face many times with a stuffed animal. Allegation #2: A Caregiver would yell at a resident. Allegation #3: A Caregiver would hit a resident with blankets and towels while providing care to the resident. The investigation into the allegations included: Observations included a tour of the facility to feel for temperatures and an operational swamp cooler, resident appearance, to include any signs and symptoms of abuse and neglect, and caregiver to resident interactions. Interviews were conducted with a Caregiver, the Owner and three residents. Document review included facility progress notes, incident reports, history and physicals, Activities of Daily Living (ADL), employee staff schedules, employee background checks and elder abuse training. The findings and conclusions of any investigation by the Division of Public and Behavioral Health shall not be	0000		

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

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	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.			