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 |
|---|---|---|---|
| | 3275 | A. BUILDING _____ B. WING _____ | 08/12/2024 |

| 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<br><br>Inspector Comments: This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted in your facility on 08/12/2024. 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 and/or persons with mental illness and/or persons with intellectual disabilities, three Category I and five Category II residents. The census at the time of survey was five. Five resident files were reviewed, and four employee files were reviewed. The facility received a grade of B. 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. The following regulatory 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: LAILA BUENVIAJE Title: Administrator Date: 09/12/2024

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 3275 | A. BUILDING _____ B. WING _____ | 08/12/2024 |

| 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 |
|---|---|---|---|---|
| 0178 SS= E | 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.<br><br>Inspector Comments: Based on observation and interview, the facility failed to ensure the ceiling plaster around a bathroom light fixture was not buckling and peeling away from the ceiling, outdoor seating for resident use did not have ripped cushions, fence boards were securely attached to fence posts and were not hanging loose from the fence line, and a screen door did not have worn and torn mesh. Findings include: On 08/12/2024 at 8:46 AM, the residents' bathroom next to bedroom four had a light fixture in the ceiling above the toilet. The ceiling around the light fixture had buckling plaster and the plaster was flaking off and falling onto the floor. The Caregiver confirmed the ceiling around the light fixture was buckling and peeling. On 08/12/2024 at 9:00 AM, an outdoor loveseat on the paved patio area off the back door of the facility had ripped cushions. An upholstered chair next to the loveseat was stained and torn with the inner foam exposed. The Caregiver confirmed the seating area was for resident use and the furniture had tears and staining. On 08/12/2024 at 9:04 AM, the side yard to the right of an outdoor shed had three loose fence boards hanging inward towards the yard. The Caregiver confirmed the fence boards were loose and needed to be repaired and secured to the fence. On 08/12/2024 at 9:06 AM, the screen on a sliding door on the exterior of bedroom two was worn and detached from the frame near the handle, and along the bottom of the frame. The Caregiver confirmed the screen had detached from the frame and was worn. Severity: 2 Scope: 2 | 0178 | 1. We hired a handy man to fix the light fixture in the bathroom, the screen in the sliding door and the fence board. A new set of cushion was placed in the seat in the patio.<br><br>2. A Maintenance log sheet will be used for broken interior/exterior in the facility.<br><br>3. We will make sure that the interior/exterior of the facility will be checked and maintenance will be done regularly.<br><br>4. Caregiver/Owner/Administrator<br><br>5. 8/12/24 | 08/12/2024 |
| 0520 SS= F | Supervision and Treatment of Residents - NAC 449.259 and R043-22 Supervision and treatment of residents generally. (NRS 449.0302) 2. A person-centered service plan developed pursuant to this section | 0520 | 1. Personalized care plan was created for each resident after survey/facility inspection. | 08/12/2024 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 3275 | A. BUILDING _____ B. WING _____ | 08/12/2024 |

| 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 |
|---|---|---|---|---|
| | must include, without limitation: (a) Provisions concerning activities of daily living, medication management, cognitive safety, assistive devices, special needs, social and recreational needs and involvement of ancillary services; (b) Protective supervision as necessary for the resident; (c) The manner in which all caregivers will be informed of the required supervision of the resident; (d) The manner in which the facility will ensure that the resident has the opportunity to attend the religious service of his or her choice and participate in personal and private pastoral counseling; (e) Permission for the resident to rest in his or her room at any time; (f) Permission for the resident to enter or leave the facility at any time if the resident: (1) Is physically and mentally capable of leaving the facility; and (2) Complies with the rules established by the administrator of the facility for leaving the facility; (g) Laundry services for the resident unless the resident elects in writing to make other arrangements; (h) The manner in which the facility will ensure that the resident's clothes are clean, comfortable and presentable; (i) A requirement that the facility must inform the resident or his or her representative of the actions that the resident should take to protect the resident's valuables; (j) A written program of activities for the resident that includes scheduled and unscheduled activities that are suited to his or her interests and capacities;<br><br>Inspector Comments: Based on record review and interview, the facility failed to ensure a person-centered service plan was developed to address the facility's treatment of residents for 5 of 5 residents reviewed for service plans (Resident #1, #2, #3, #4, and #5). Findings include: The following residents' records lacked documented evidence of a person-centered service plan to address the treatment needs of the residents by the facility's caregiver staff: - Resident #1 was admitted to the facility on 04/25/2023, with diagnoses including hypertension, bipolar disorder, and depression. - Resident #2 was admitted to the facility on 09/01/2022, with a diagnosis of age-related physical debility. - Resident | | 2. We will make sure that each resident will have his/her own care plan.<br><br>3. We will ensure that each resident has a care plan and update it as deemed necessary.<br><br>4. The Administrator<br><br>5. 8/12/24 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 3275 | A. BUILDING _____ B. WING _____ | 08/12/2024 |

| 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 |
|---|---|---|---|---|
| | #3 was admitted to the facility on 04/03/2024, with a diagnosis of unspecified atrial fibrillation, malignant. - Resident #4 was admitted to the facility on 12/11/2023, with a diagnosis of trauma/fall. - Resident #5 was admitted to the facility on 07/30/2024, with diagnoses including non-ST segment elevation myocardial infarction, asthma, and pulmonary edema. On 08/12/2024 at 9:45 AM, the Administrator confirmed the facility had not created person-centered service plans for the residents currently residing in the facility affecting 5 of 5 residents. Severity: 2 Scope: 3 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 3275 | A. BUILDING _____ B. WING _____ | 08/12/2024 |

| 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 |
|---|---|---|---|---|
| 0870 SS= D | Medication Administration-Accuracy & Report - NAC 449.2742 Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall: (a) Ensure that a physician, pharmacist or registered nurse who does not have a financial interest in the facility: (1) Reviews for accuracy and appropriateness, at least once every 6 months the regimen of drugs taken by each resident of the facility, including, without limitation, any over-the-counter medications and dietary supplements taken by a resident; and (2) Provides a written report of that review to the administrator of the facility. (b) Include a copy of each report submitted to the administrator pursuant to paragraph (a) in the file maintained pursuant to NAC 449.2749 for the resident who is the subject of the report. (c) Make and maintain a report of any actions that are taken by the caregivers employed by the facility in response to a report submitted pursuant to paragraph (a).<br><br>Inspector Comments: Based on interview and clinical record review, the Administrator failed to ensure a Pharmacy Review was completed at least once every six months for 1 of 5 sampled residents in the facility longer than six months (Resident #2). Findings include: Resident #2 Resident #2 was admitted to the facility on 09/01/2022, with a diagnosis of age-related physical debility. Resident #2's clinical record included the two most recent Pharmacy Reviews completed on 12/13/2023 and 07/22/2024, but lacked a Pharmacy Review completed on or before 06/13/2024. On 08/12/2024 at 11:05 AM, the Owner and the Administrator confirmed Resident #2 did not have a six-month Pharmacy Review prior to their due date in June 2024. Severity: 2 Scope: 1 | 0870 | 1. Medication review was completed on 7/22/24 instead on 6/13/24 due to resident's PCP wanted to see patient before signing the medication review. Patient's daughter was able to schedule appointment on 7/22/24 with PCP, and that was the soonest available appointment that she can get when she called in May 2024 to schedule an appointment.<br><br>2. We have a log noting medication review due date for each resident.<br><br>3. We do medication review every 6 months as noticed with the other residents. We will make sure that this will be done timely.<br><br>4. The Administrator.<br><br>5. Medication review was completed on 7/22/24. | 07/22/2024 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 3275 | A. BUILDING _____ B. WING _____ | 08/12/2024 |

| 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 |
|---|---|---|---|---|
| 0874 SS= D | Medication Administration-Report Received - NAC 449.2742 and R043-22 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 2. Within 72 hours after the administrator of the facility receives a report submitted pursuant to paragraph (a) of subsection 1, a member of the staff of the facility shall notify the resident's physician, physician assistant or advanced practice registered nurse of any concerns noted by the person who submitted the report. The report must be reviewed and initialed by the administrator.<br><br>Inspector Comments: Based on interview and clinical record review, the Administrator failed to ensure a medication profile review, performed by a physician, pharmacist, or registered nurse at least once every six months, was reviewed and initialed by the Administrator within 72 hours for 1 of 5 sampled residents residing in the facility for longer than six months (Resident #2). Findings include: Resident #2 Resident #2 was admitted to the facility on 09/01/2022, with a diagnosis of age-related physical debility. On 08/12/2024 at 11:05 AM, the Owner confirmed the medication profile review dated 07/22/2024 lacked the Administrator's initials, indicating the Administrator's review within 72 hours of receiving the report. Severity: 2 Scope: 1 | 0874 | 1. Medication review was signed by the Administrator after facility survey/inspection.<br><br>2. We will make sure that Medication review will be reviewed and signed by the Administrator within 72 hours after MD signed reviewed it.<br><br>3. The Administrator will check medication review received by the facility regularly and sign in a timely manner.<br><br>4. Administrator.<br><br>5. 8/12/24 | 08/12/2024 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 3275 | A. BUILDING _____ B. WING _____ | 08/12/2024 |

| 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 |
|---|---|---|---|---|
| 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.<br><br>Inspector Comments: Based on interview and clinical record review, the facility failed to ensure 1 of 5 sampled residents met the requirements concerning tuberculosis (TB) testing in accordance with Nevada Administrative Code (NAC) 441A (Resident #1). Findings include: Resident #1 Resident #1 was admitted to the facility on 04/25/2023, with diagnoses including hypertension, bipolar disorder, and depression. Resident #1's clinical record documented an initial TB test completed on 01/24/2023 and a QuantiFERON gold TB test completed on 03/13/2024. Resident #1's clinical record lacked documentation of an annual TB test administered within 12 months of the initial test. On 08/12/2024 at 9:28 AM, the Owner confirmed the resident had not been tested for TB within 12 months of the initial TB test. Severity: 2 Scope: 1 | 0936 | 1. Resident's annual TB test was due on 1/24/24 (Patient's previous annual TB test completed on 1/24/23). Patient was not able to get a 1 step TB skin test before 1/24/24 and instead had a Quantiferon Gold TB test done on 3/13/24.<br><br>2. We make sure that residents have TB test done within 12 months.<br><br>3. We will check and take note of the TB test due date for each resident and make sure test will be done annually.<br><br>4. Administrator<br><br>5. Quantiferon Gold TB test completed on 3/13/24 | 03/13/2024 |
| 1600 SS= C | Preferred Name/Pronoun P& P - Preferred Name/Pronoun P& P R016-20 Sec. 19 1. A facility shall: (a) Develop policies to ensure that a patient or resident is addressed by his or her preferred name and pronoun and in accordance with his or her gender identity or expression; and (b) Adapt electronic records and any paper records the facility has to reflect the gender identities or expressions of patients or residents with diverse gender identities or expressions, including, without limitation: (2) If the facility is a facility for the dependent or other residential facility, adapting electronic | 1600 | 1. Residents name/preferred name, gender and pronoun could be found in all residents medical records. It is written in the resident's facesheet as well. All of the residents are being called with their names as they preferred it. We included the name, nickname, gender, and preferred pronoun in the care plan.<br><br>2. We will make sure that all information regarding name/preferred name, gender and pronoun of each resident | 08/12/2024 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 3275 | A. BUILDING _____ B. WING _____ | 08/12/2024 |

| 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 |
|---|---|---|---|---|
| | records and any paper records the facility has to include the preferred name and pronoun and gender identity or expression of a resident. R016-20 Sec. 19 2. If a patient or resident chooses to provide the following information, the health records adapted pursuant to subparagraph (1) of paragraph (b) of subsection 1 must include, without limitation: (a) The preferred name and pronoun of the patient or resident; (b) The gender identity or expression of the patient or resident; (c) The gender identity or expression of the patient or resident that was assigned at the birth of the patient or resident; (d) The sexual orientation of the patient or resident; and (e) If the gender identity or expression of the patient or resident is different than the gender identity or expression of the patient or resident that was assigned at the birth of the patient or resident: (1) A history of the gender transition and current anatomy of the patient or resident; and (2) An organ inventory for the patient or resident which includes, without limitation, the organs: (I) Present or expected to be present at the birth of the patient or resident; (II) Hormonally enhanced or developed in the patient or resident; and (III) Surgically removed, enhanced, altered or constructed in the patient or resident. R016-20 Sec. 20 1. Except as otherwise provided in subsection 2, the statements, notices and information required by sections 2 to 22, inclusive, of this regulation and NRS 449.101 to 449.104, inclusive, must be in English and, as appropriate for a facility, in any other language the Department determines is appropriate based on the demographic characteristics of this State. In addition to the notices and information provided in English and any other language the Department determines is appropriate based on the demographic characteristics of this State, a facility may provide the statements, notices and information in any other language the facility may desire. R016 -20 Sec. 20 2. A facility must make reasonable accommodations in providing the statements, notices and information described in subsection 1 for patients or residents who: (a) Are unable to read; (b) Are blind or visually impaired; (c) Have | | will be in a page put infront of resident's chart.<br><br>3. We will write all these information in a sheet so it can easily be found by the person caring for the resident.<br><br>4. Caregiver, Owner, Administrator<br><br>5. 8/12/24 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 3275 | A. BUILDING _____ B. WING _____ | 08/12/2024 |

| 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 |
|---|---|---|---|---|
| | communication impairments; or (d) Do not read or speak English or any other language in which the statements, notices and information are written pursuant to subsection 1.<br><br>Inspector Comments: Based on clinical record review and interview, the facility failed to ensure there were policies developed and resident records in compliance with R016-20 Section 19, regarding resident records to reflect a resident's preferred name, pronoun, gender identity or expression, and sexual orientation, affecting 5 of 5 residents (Residents #1, #2, #3, #4, and #5). Findings include: Resident #1 was admitted to the facility on 04/25/2023, with diagnoses including hypertension, bipolar disorder, and depression. Resident #2 was admitted to the facility on 09/01/2022, with a diagnosis of age-related physical debility. Resident #3 was admitted to the facility on 04/03/2024, with a diagnosis of unspecified atrial fibrillation, malignant. Resident #4 was admitted to the facility on 12/11/2023, with a diagnosis of trauma/fall. Resident #5 was admitted to the facility on 07/30/2024, with diagnoses including non-ST segment elevation myocardial infarction, asthma, and pulmonary edema. On 08/12/2024, in the morning, the 5 sampled resident clinical records reviewed, Residents #1, #2, #3, #4, and #5 lacked documentation to be in compliance with R016-20 Section 19. On 08/12/2024 at 11:05 AM, the Owner and the Administrator confirmed there were no changes to resident clinical records in compliance with the regulation. Severity: 1 Scope: 3 | | | |