

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 01/03/2018	
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 conducted in your facility on 01/03/18. This investigation was conducted by the authority of NRS 449.0307 (NRS 439.150), Powers of the Division of Public and Behavioral Health. The census at the time of the survey was 6. The sample size was 5. There was one complaint investigated. Complaint #NV00051419 could not be substantiated. The allegation the facility failed to administer a resident's medication per the physician's order 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. Five resident files were reviewed, including the residents of concern. 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 investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. There were no regulatory deficiencies identified. No further action is necessary.	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.