

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  <b>01/04/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>EVERLASTING SENIOR CARE, LLC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE  <b>2117 CALIFORNIA ST, CARSON CITY, NEVADA ,89701</b>	

(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	<p>Initial Comments</p> <p>Inspector Comments: This Statement of Deficiencies was generated as a result of a complaint investigation survey conducted at your facility on 01/04/24. 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 is licensed for six Residential Facility for Group beds for elderly and disabled persons, and/or persons with mental illness, three Category I residents and three Category II residents. The census at the time of the survey was five. Five resident files were reviewed. The facility received a grade of A. There were two complaints investigated. Complaint #NV00069999 with the allegation a resident eloped from the facility could not be substantiated. The investigation into the allegations included: Observation of the common areas and resident rooms. Interviews were conducted with three residents including the resident of concern and the the Administrator. Review of six resident records including the resident of concern. The review included admission records, Activities of Daily Living (ADL) Assessments, Standard Physician Assessments, Physician Placement Determination, and a Serious Occurrence Report. Review of facility documents including Resident Rights, House Rules, and staffing schedule. Complaint #NV00069713 with the following allegations could not be substantiated. Allegation #1: a resident eloped from the facility. Allegation #2: the caregiver would sleep and not provide supervision of the residents. Allegation #3: a resident was left soiled for long periods of time. Allegation #4: the facility was dirty. Allegation #5: food does not meet dietary needs and was not healthy. The investigation into the allegations included: Observation of the common areas, resident rooms, and backyard. Interviews were conducted with</p>	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER Name: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_  
REPRESENTATIVE'S SIGNATURE

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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