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
	9560	A. BUILDING _____ B. WING _____	05/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN LIVING LLC	**7481 ROME BLVD, LAS VEGAS, NEVADA ,89131**

(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 an Annual State Licensure and infection control survey conducted at your facility on 5/25/21, in accordance with Nevada Administrative Code (NAC), Chapter 449, Residential Facilities for Groups. The facility is licensed for ten Residential Facility for Group beds for elderly and disabled persons and/or persons with Alzheimer's disease, Category II residents. The census at the time of the survey was eight. Eight resident files and four employee files were reviewed. The facility received a grade of A. 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. The following regulatory deficiencies were identified:	0000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9560	A. BUILDING _____ B. WING _____	05/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN LIVING LLC	7481 ROME BLVD, LAS VEGAS, NEVADA ,89131

(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
0050 SS= F	Administrator's Responsibilities - Oversight - NAC 449.194 Responsibilities of administrator. (NRS 449.0302) The administrator of a residential facility shall: 1. Provide oversight and direction for the members of the staff of the facility as necessary to ensure that residents receive needed services and protective supervision and that the facility is in compliance with the requirements of NAC 449.156 to 449.27706, inclusive, and chapter 449 of NRS. Inspector Comments: Based on observation and interview, the facility failed to implement safe infection control practices for the protection of residents in response to the COVID-19 Pandemic. Findings include: On 05/25/21 at 8:00 AM, the Health Facility Inspector was not asked COVID-19 screening questions related to symptoms, travel history, and exposure to the virus at other facilities prior to entry to the facility; and was not asked to perform hand hygiene. Three Caregivers were not wearing a face mask and residents were not encouraged to socially distance. There were no employees fit tested and medically cleared to wear an N95 mask. At 11:00 AM, a visitor was not asked COVID-19 screening questions prior to entering the facility. The Caregiver verbalized all visitors and staff members were screened for temperature checks but were not screened for COVID-19 questions because the residents were vaccinated. The Administrator acknowledged none of the employees were N95 fit tested and medically cleared to wear an N95 mask. The Administrator reported being unaware employees needed to continue to wear a face mask if they were vaccinated. Severity: 2 Scope: 3	0050	1. The facility staff have been instructed to follow the COVID-19 safety inspection control at all times. An N95 Fit test was obtained for an employee. 2. To ensure the deficient practice does not recur, face masks and COVID-19 questions will be available at the entrance. 3. The Administrator will ensure compliance during her visits to the facility. 4. 6/8/2021.	06/08/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9560	A. BUILDING _____ B. WING _____	05/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN LIVING LLC	7481 ROME BLVD, LAS VEGAS, NEVADA ,89131

(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
0930 SS= F	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: (a) The full name, address, date of birth and social security number of the resident. (b) The address and telephone number of the resident ' s physician and the next of kin or guardian of the resident or any other person responsible for the resident. (c) A statement of the resident ' s allergies, if any, and any special diet or medication he or she requires. Inspector Comments: Based on observation and interview, the facility failed to ensure medical records were secured for 8 of 8 sampled residents (Resident #1, #2, #3, #4, #5, #6, #7 and #8). Findings include: On 05/25/21 at 8:00 AM, during a facility tour, a hallway closet and a storage cabinet containing residents' files were unlocked and not secured. The Caregiver acknowledged the closet door and storage cabinet were unlocked and the residents' files were not secured. The Caregiver indicated the closet door and storage cabinet should have been locked. Severity: 2 Scope: 3	0930	1. The storage file has been locked. The facility staff have been instructed to ensure that storage files is secured and locked at all times. 2. To ensure that the deficient practice does not recur, a Facility Checklist will be used during daily walk-around of the facility. 3. The Administrator will ensure compliance during her daily visit to the facility. 4. 6/8/2021.	06/08/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9560	A. BUILDING _____ B. WING _____	05/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN LIVING LLC	7481 ROME BLVD, LAS VEGAS, NEVADA ,89131

(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
0999 SS= F	Alzheimer 's Care Standards for Safety - NAC 449.2756 Residential facility which provides care to persons with Alzheimer ' s disease: Standards for safety; personnel required; training for employees. (NRS 449.0302) 1. The administrator of a residential facility which provides care to persons with Alzheimer ' s disease shall ensure that: (g) All toxic substances are not accessible to the residents of the facility. Inspector Comments: Based on observation and interview, the facility failed to ensure toxic substances were not accessible to residents. Findings include: On 05/25/21 at 8:15 AM, a laundry room door was unlocked and opened. There was a bucket of liquid laundry detergent inside an unlocked cabinet. A Caregiver acknowledged the door was opened and the cabinet was not secured. The Caregiver verbalized the cabinet should have been locked to prevent resident access. Severity: 2 Scope: 3	0999	1. The cabinet that contains the toxic substance was locked. The facility staff have been instructed to ensure all toxic substances are not accessible to residents. 2. To ensure the deficient practice does nor recur, a Facility Checklist will be used during daily rounds of the facility. 3. The Administrator will monitor compliance during her visits to the facility. 4. 6/8/2021.	06/08/2021