STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675035	A. BUILDING _____ B. WING _____	**03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
EVERGREEN HEALTHCARE CENTER	**406 E SEVENTH ST BURKBURNETT, TX 76354**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0912 **Level of harm -** Potential for minimal harm **Residents Affected -** Some	**Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that 1 of 31 resident rooms (room # 15) met minimum required square footage for each resident. The facility's failure could affect residents, if housed in room [ROOM NUMBER], by not affording them appropriate living space which could adversely affect residents from attaining his or her highest practicable wellbeing. The findings included: An interview with the Administrator, on [DATE]20 at 9:28 AM, revealed the facility did have a room size waiver, in place, for resident room # 15. This interview revealed the facility would like to continue with the room size waiver. An observation of East wing, room [ROOM NUMBER], on 03/05/2020 at 1:42 PM, revealed the room measured at 218.8 square feet. Room # 15 was being utilized as the therapy room, with therapy equipment in this area. No residents were housed in this room. The room was certified to have 3 beds, which required at least 240 square feet. Review of the facility's floor plan, updated 05/14/2013, revealed room [ROOM NUMBER] was being utilized for resident's physical, occupational, and speech therapy. Review of the Form 3740 Bed Classifications, dated [DATE]20, completed by the Administrator, revealed room [ROOM NUMBER] had 3 Title 18 beds. * Waiver requested to be continued.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) 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.