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	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**02/22/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHUTNEY RESIDENTIAL HOME	**3881 CHUTNEY ST, LAS VEGAS, NEVADA ,89121**

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a complaint investigation completed at your facility on 02/22/22, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The census at the time of the survey was six. The sample size was five. There was one complaint investigated. The facility received a grade of B. Complaint #NV00065552 with three allegations was substantiated. Allegation #1: An area designated for Caregivers was unlocked; leading to an outside cluttered area and a hanging clothesline in the backyard. (See Tag Y0178) Allegation #2: Two large breed dogs were observed walking around the facility was substantiated without deficiencies based on two residents who verbalized they did not feel threatened by the dogs. One dog was observed on a leash in the backyard. One dog was out of sight, upstairs. Both dogs were not observed to display safety concerns at the time of the survey. The following deficiency could not be substantiated: Allegation #3: Facility did not have a specific dining area and a dining table for residents was unsubstantiated based on observation of two residents eating breakfast at the table in the dining room. The investigation into the allegations included: Observations of the interior and exterior of the facility. Interviews with two residents, and the Administrator. Regulatory deficiencies not related to the complaint allegation were identified during the course of the complaint investigation. (See Tags Y0050, Y592, Y991 and Y994) 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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: CRISANTA PASION Title: Administrator Date: 03/25/2022

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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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 and staff in response to the COVID-19 Pandemic. Findings include: On 02/22/22 at 8:40 AM, the Health Facility Inspector was not provided a COVID-19 screening related to symptoms, travel history, and exposure to the virus. A temperature check was not performed prior to being allowed entry to the facility. Two employees were not wearing face masks. The Administrator acknowledged a face mask should have been worn while providing care to the residents and a COVID-19 screening should have been conducted prior to entry into the facility. Severity: 2 Scope: 3	0050	1. Inspection findings were discussed with staff (3/22/22). 2.Thermometer and COVID screening form were placed in the sign-in sheet so that caregivers will remember to do the screening and temperature checks before someone comes in the facility. Staff were all reminded to wear masks at all times (3/22/22).	03/25/2022
0178 SS= F	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. Inspector Comments: Based on observation and interview the facility failed to ensure the exterior and interior premises was maintained. Findings include: On 02/22/22 at 8:40 AM, the following was observed: - A garbage bag filled with garbage items was in front of the garage. - An unlocked door leading to the garage had several bags of garbage, opened boxes, clothing and toxic	0178	1. Caregiver was still cleaning when inspector came. Garbage in front of the garage was thrown in the trash bin after caregiver collected trash (2/22/22). The door leading to the garage which has a sign that states "Not an Exit.Staff Only" was accessible only to employees was locked when pointed out by inspector. The clothes that were owned by past residents and not picked up by their families were disposed of. The garbage and opened boxes were thrown away. Common area-The things on top of the table were organized (3/22/22). The pillows were from the couch where resident laid were placed back where they belong when resident got up (2/22/22). The clothes that	03/25/2022

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	chemicals. - A common area had excessive garbage on a table, seven pillows on a couch, two mats, three rolls of toilet paper and clothing scattered on a recliner and sofa. - Two dining tables inside the kitchen had piles of bread and multiple pieces of unopened mail. - A bathroom had two incontinence pads on the floor. - The backyard had a low hanging cable cord with a towel draped over it. - A patio table in the backyard had excessive garbage on top of the table. - A long hallway leading to the outside gate had multiple hangers, clothing and shoes, two chairs, one large cabinet, two empty detergent containers and several large boxes. On 02/22/22 at 8:40 AM, the Administrator acknowledged the interior and exterior of the facility was not maintained, per the requirement. Severity: 2 Scope: 3 Complaint#NV00065552		were laundered were folded and given to resident. (2/22/22). The toilet paper rolls for refill were temporarily placed in the couch by caregiver because a resident was using the bathroom when caregiver was supposed to place it. Toilet paper rolls were placed in the bathroom when resident came out (2/22/22). Dining table- Administrator sorted and discarded unwanted mails on the long table as mentioned to the inspector (2/22/22). The corner smaller table is actually designated for the bread. Bathroom- These incontinence pads are clean and changed every single day because this is what one of the residents asked for. Backyard- The cable cord where the towel was hanging was removed (2/22/22) and the table was cleared (2/22/22). Long Hallway- The long hallway is not accessible to residents. Residents have never gone out this way. It is padlocked both front and back. The only access is through the caregiver's room side door and that's why it's used as storage by caregiver. The boxes of diaper and underpads were moved in the locked area behind the shed and the hangers, clothing, and shoes were organized (3/23/22) The large cabinet and chairs are still used by caregiver. 2. Administrator told staff to maintain interior and exterior of facility regularly and as needed. Administrator will monitor for compliance (3/23/22).	

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0592 SS= D	Rights of Residents; Procedure for Filing - NAC 449.268 Rights of residents; procedure for filing grievance, complaint or report of incident; investigation and response. (NRS 449.0302) 1. The administrator of a residential facility shall ensure that: (c) The residents are treated with respect and dignity; Inspector Comments: Based on interview and record review, the facility failed to ensure a resident was treated with dignity and respect for 1 of 6 sampled residents (Resident #1). Findings include: Resident #1 (R1) R1 was admitted on 04/01/20, with diagnoses of dementia and depressive disorder. On 02/22/22 at 8:40 AM, R1 was observed receiving personal hygiene assistance in the common area of the facility by the Administrator. R1 was lying on the couch undressed below the waist, and was not wearing a brief. The Administrator acknowledged R1 was undressed below the waist while lying on the couch in the common area. The Administrator acknowledged R1's personal hygiene should have been completed in R1's room. Severity: 2 Scope: 1	0592	1. Resident defecated in the living room. To prevent more mess, administrator decided to clean resident before transferring her into her wheelchair. Administrator tried to maintain as much privacy when she helped the resident. It was only the administrator and the resident in the living room. The other caregiver was cleaning in the backyard. All the residents were in their rooms except for one who was in the dining room watching TV and having breakfast. Resident can't be seen from the dining room because there's a couch that blocks her view. Administrator was not expecting visitors to come this early either. Administrator cleaned resident before transferring her in the wheelchair and wheeled her in the bathroom (2/22/22). 2. The next time this happens, administrator will bring resident to the closest bathroom.	03/25/2022

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0991 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: (b) Operational alarms, buzzers, horns or other audible devices which are activated when a door is opened are installed on all doors that may be used to exit the facility. Inspector Comments: Based on observation and interview, the facility failed to ensure an audible alarm system was activated on 3 of 3 doors exiting the facility. Finding include: On 02/22/22, at 8:40 AM, during a tour of the facility, the audible alarm system on three exit doors, leading to the front yard, garage and the backyard was not activated. The Caregiver acknowledged the alarms were not turned on. The Administrator verified the exit doors' alarms were inoperable. The Administrator indicated all door alarms should have been working. Severity: 2 Scope: 3	0991	1) Alarms (front-main entry, garage-laundry, backyard-trash bin) were turned on by caregiver (2/22/22). Caregiver stated that he turned it off so as not to disturb the resident who fell asleep in the living room watching TV by hospice CNA who comes in early in the morning (5:00 am) 2) Administrator had a meeting with caregivers and told everyone to leave alarms on at all times (3/23/22). Administrator to check for compliance.	03/25/2022

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0994 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: (e) Knives, matches, firearms, tools and other items that could constitute a danger to the residents of the facility are inaccessible to the residents. Inspector Comments: Based on observation and interview, the facility failed to ensure sharp items were not accessible to residents. Findings include: On 02/22/22 at 8:45 AM, the following was observed: - Multiple knives were observed in an unlocked kitchen cabinet; -A pair of scissors was observed on the kitchen counter; and - An electric razor and a screwdriver was observed in a resident's room. The Administrator acknowledged the knives, electric razor, scissors and a screwdriver were unsecured. The Administrator indicated all sharp items should have been locked up and not accessible to the residents. Severity: 2 Scope: 3	0994	1. Drawer where multiple knives were located was locked (2/22/22). The pair of scissors was secured (2/22/22). Resident refused to give his electric razor and screwdriver he uses for his motorized wheelchair for safekeeping so administrator gave resident a lock box to use to keep these things. 2. Caregivers were reminded to lock the drawer for knives always and secure all sharps once used (3/22/22). Administrator to monitor for compliance.	03/25/2022