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
	2788	A. BUILDING _____ B. WING _____	05/07/2024

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

(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 survey completed at your facility on 05/07/24, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for seven 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 five. Five resident files and four employee files were reviewed. The facility received a grade of D. 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
	2788	A. BUILDING _____ B. WING _____	05/07/2024

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

(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
0174 SS= F	Health& Sanitation-odors-hazards-insects-dirt - NAC 449.209 Health and sanitation. (NRS 449.0302) 4. To the extent practicable, the premises of the facility must be kept free from: (a) Offensive odors; (b) Hazards, including obstacles that impede the free movement of residents within and outside the facility; (c) Insects and rodents; and (d) Accumulations of dirt, garbage and other refuse. Inspector Comments: Based on observation and interview, the facility failed to ensure the facility was free from rodent feces. Findings include: On 05/07/24 in the morning, in the garage, the hallway and stairs leading to the upstairs bedroom was covered in feces, from what appeared to be a rodent. The hallway and bedroom upstairs were covered with an abundance of personal items and trash in an unorganized fashion with very little walkway. On 05/07/24 in the morning, the Administrator confirmed the facility had a rodent problem which the facility had eradicated, however, the rodent feces had not been cleaned up. The Administrator was unable to provide documented evidence the rodents were eradicated. The Administrator acknowledged the refuse in the hallway and bedroom and had no explanation as to the reason for it. Severity: 2 Scope: 3	0174	1. Garage, hallway, and stairs leading to upstairs bedroom was cleared. This room which has been abandoned for years will be again occupied by new house help. The clearing of the upstairs bedroom is still ongoing. This area of the house is not accessible to residents. Resident and staff has not seen a rodent or rodent feces in resident's living area (rooms, living room, kitchen, and dining room) for several months now. 2 Facility continues to employ monthly pest control services to ensure that facility remains to be rodent free.	08/29/2024
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 interior and exterior of the facility was well maintained. Findings include: On 05/07/24 in the morning, observations of multiple areas of the home were cluttered with dirt build-up: In the dining room area were various boxes and bags of unknown personal belongings and other items that were stacked along the three walls that lined the dining room area. The dining room table was cluttered with mail and other	0178	1. -Boxes, bags, and personal belongings lining the wall were cleared from the wall. -Dining room table was cleared. -The refrigerator and 2 freezers outside were used while the kitchen refrigerator was broken. A new refrigerator was bought to replace the broken one in the kitchen (7/5/24). -Pots, pans, cooking equipment, and dishes were recently used to prepare breakfast during which inspector arrived. -Caregiver left it in the counter to air dry as she had to leave early for her appointment. Counter was cleaned and cleared on day of inspection. -Living room desk was decluttered. -Weeds were pulled in the front yard -Bed/floor underneath cleaned -Backyard patio was decluttered. -	08/29/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2788	A. BUILDING _____ B. WING _____	05/07/2024

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

(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
	assorted items, and not more than two residents could eat at the table. The kitchen refrigerator was broken and not operational. The refrigerator contained no food but contained a foul odor. The kitchen counters were cluttered with drying dishes, pots and pans and cooking equipment, leaving minimal space for preparation and cooking of food. The kitchen counters were soiled with food debris and other grime. The living room area contained a desk, office equipment, personal items and paper work were located on top of the desk and other items cluttering the room. The front yard had an abundance of weeds. The table on the patio in the backyard was cluttered with various kitchen items. The patio in the backyard had one small pile and one large pile of boxes and bags of various staff personal items and kitchen items. There was broken and warped wood used as a walkway to the shed. The floor throughout the facility and under resident beds was soiled with dirt, lint, and other debris. All residents' beds, wheelchairs, walkers, and oxygen concentrators had a heavy dust build-up. All bathroom showers, toilets, counters, and mirrors were soiled with dust, dirt, and other debris. Light switches throughout the facility were soiled with unknown substances. Baseboards, fans, and vents throughout the facility were soiled with heavy dust-build up. On 05/07/24 in the morning, the Administrator acknowledged the areas the surveyor identified inside and outside of the facility needed to be cleaned for resident access and use. This was a repeat deficiency from the 10/10/23 State Licensure survey. Severity: 2 Scope: 3		2. Administrator hired house help to help with the cleaning and upkeep of the facility.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2788	A. BUILDING _____ B. WING _____	05/07/2024

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

(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
0320 SS= F	Bedroom - Doors: Locks - NAC 449.220 Bedroom doors. (NRS 449.0302) 1. A bedroom door in a residential facility which is equipped with a lock must open with a single motion from the inside unless the lock provides security for the facility and can be operated without a key or any special knowledge. Inspector Comments: Based on observation and interview, the facility failed to ensure doors had a single motion lock. Findings include: On 05/07/24 in the morning, all bedroom doors had a lock on the door which required a key to unlock from the outside of the bedroom. On 05/07/24 in the morning, the Administrator indicated thinking the facility required the locks on the doors. The Administrator was unaware of the requirement resident rooms required a single motion lock. Severity: 2 Scope: 3	0320	1. Doors were all changed to single motion locks (5/9/23). The facility originally had this type of lock on all the bedrooms. However, during the December 12, 2023 Medicaid inspection, the facility was written up for having this type of lock citing privacy issues. The Medicaid personnel said that as long as the staff has access to the key to open it during emergency, then it should be okay. 2. Facility will no longer have this deficiency as all bedroom locks were changed back to single motion locks. Administrator will refer to DPBH if there is a discrepancy with Medicaid regulation.	05/09/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2788	A. BUILDING _____ B. WING _____	05/07/2024

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

(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
0430 SS= F	Requirements and Precautions - NAC 449.229 Requirements and precautions regarding safety from fire. (NRS 449.0302) 1. The administrator of a residential facility shall ensure that the facility complies with the regulations adopted by the State Fire Marshal pursuant to chapter 477 of NRS and all local ordinances relating to safety from fire. The facility must be approved for residency by the State Fire Marshal. 2. The Bureau shall notify the State Fire Marshal or the appropriate local government, as applicable, if, during an inspection of a residential facility, the Bureau knows of or suspects the presence of a violation of a regulation of the State Fire Marshal or a local ordinance relating to safety from fire. Inspector Comments: Based on observation, interview, and document review, the facility failed to ensure smoke detectors were in working order and the fire alarm was not impaired. Findings include: On 05/07/24 in the morning, the smoke detector in the living room and at the top of the stairs were beeping. On 05/07/24 in the morning, the fire alarm panel was black with no lights. The inspection tag dated 06/06/23, documented impaired. The fire inspection report dated 12/01/23, documented the box was checked that the fire alarm was not operating. On 05/07/24 in the morning, the Administrator acknowledged the beeping smoke alarm and indicated the batteries should have been replaced. The Administrator reported they were waiting on a part for the fire alarm and did not have an indication as to when the part would be available. On 05/07/24 in the morning, the fire inspector reported the fire alarm panel was no longer operating and the facility needed a new panel; however, if there were fire sprinklers, buzzers, and strobe lights that were operating properly. Severity: 2 Scope: 3	0430	1. Smoke detector battery in living room and top of stairs were replaced after inspection (5/7/24). The fire alarm panel was installed (5/28/24). Electrician originally told administrator that there is a missing part and he'll talk to technician about it. However when technician visited months after, he said problem is not fixed yet and electrician hasn't spoken to him. Administrator did the transaction instead. Fire alarm was checked and cleared (7/30/2024). 2. Administrator will follow up on future transactions for faster service.	05/28/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2788	A. BUILDING _____ B. WING _____	05/07/2024

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

(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
0859 SS= E	Medical Care of Resident After Illness - NAC 449.274 and R043-22 Medical care of resident after illness, injury or accident; periodic physical examination of resident; rejection of medical care by resident; written records. (NRS 449.0302) 5. Before admission and each year after admission, or more frequently if there is a significant change in the physical condition of a resident, the facility shall obtain the results of a general physical examination of the resident by a qualified provider of health care in accordance with NRS 449.1845. The resident must be cared for pursuant to any instructions provided by the qualified provider of health care. Inspector Comments: Based on record review and interview, the facility failed to ensure 2 of 5 residents (Resident #1, and #4) received an annual physical examination. Findings include: Resident #1 (R1) R1 was admitted on 05/03/23, with a diagnosis of Alzheimer's disease. R1's last documented physical examination was dated 05/06/23. R1's file lacked documented evidence of an annual physical examination. Resident #4 (R4) R4 was admitted on 05/02/23, with diagnosis including high blood pressure. R4's file lacked documented evidence of an initial and annual physical examination. On 05/07/24 in the morning, the Administrator acknowledged the resident files lacked documented evidence of an initial or annual physical examination and was unable to provide documented evidence. Severity: 2 Scope: 2	0859	1. Both residents were delivered to the facility with no admission paperwork at hand. Administrator had to call provider to come do physical for both residents. PCP did the physical for both residents on 5/6/23. Resident#4's file was inserted on Resident # 1's file. 2. Administrator will not accept prospective residents without complete admission paperwork. Administrator to check resident files and organize it for easier visibility of paperwork needed. Annual physical was done for both residents on 5/8/23.	05/08/2024
0870 SS= F	Medication Administration-Accuracy & Report - NAC 449.2742 Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall: (a) Ensure that a physician, pharmacist or registered nurse who does not have a financial interest in the facility: (1) Reviews for accuracy and appropriateness, at least once every 6 months the regimen of drugs taken by each resident of the facility, including, without limitation, any over-the-	0870	1. The most recent medication review was requested by administrator from the provider the day after inspection (5/8/2023). 2. Administrator will create reminders for resident's 6-month medication review and check resident files monthly to ensure completeness of resident file.	05/08/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2788	A. BUILDING _____ B. WING _____	05/07/2024

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

(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
	counter medications and dietary supplements taken by a resident; and (2) Provides a written report of that review to the administrator of the facility. (b) Include a copy of each report submitted to the administrator pursuant to paragraph (a) in the file maintained pursuant to NAC 449.2749 for the resident who is the subject of the report. (c) Make and maintain a report of any actions that are taken by the caregivers employed by the facility in response to a report submitted pursuant to paragraph (a). Inspector Comments: Based on record review and interview, the facility failed to ensure a medication regimen review was completed every six months for 5 of 5 residents (Resident #1, #2, #3, #4, and #5). Findings include: Resident #1 (R1) R1 was admitted on 05/03/23, with a diagnosis of Alzheimer's disease. R1's file lacked documented evidence of a medication review. Resident #2 (R2) R2 was admitted on 08/22/23, with diagnosis including anxiety, cellulitis, and depression. R2's file lacked documented evidence of a medication review. Resident #3 (R3) R3 was admitted on 09/28/23, with diagnosis including protein calorie malnutrition and acute renal failure. R3's file lacked documented evidence of a medication review. Resident #4 (R4) R4 was admitted on 05/02/23, with diagnosis including high blood pressure. R4's file lacked documented evidence of a medication review. Resident #5 (R5) R5 was admitted on 05/26/23, with diagnosis including blindness and chronic back pain. R5's file lacked documented evidence of a medication review. On 05/07/24 in the morning, the Administrator acknowledged the resident files lacked documented evidence of a medication review and was unable to provide the missing documents. Severity: 2 Scope: 3			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2788	A. BUILDING _____ B. WING _____	05/07/2024

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

(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
0876 SS= E	Medication Administration - NRS 449.0302 - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 4. Except as otherwise provided in this subsection, a caregiver shall assist in the administration of medication to a resident if the resident needs the caregiver's assistance. A caregiver may assist the ultimate user of: (a) Controlled substances or dangerous drugs only if the conditions prescribed in subsection 6 of NRS 449.0302 are met. (b) Insulin using an auto-injection device only if the conditions prescribed in NRS 449.0304 and NAC 449.1985 are met. Inspector Comments: Based on interview and record review, the facility failed to ensure an ultimate user agreement, authorizing the facility to administer medications to a resident, was signed and dated for 2 of 5 residents (Resident #3 and #4). Findings include: Resident #3 (R3) R3 was admitted on 09/28/23, with diagnosis including protein calorie malnutrition and acute renal failure. Resident #4 (R4) R4 was admitted on 05/02/23, with diagnosis including high blood pressure. R3 and R4's ultimate user agreement was not signed or dated by the resident and/or responsible party or a facility representative. On 05/07/24 in the afternoon, a review of R3 and R4's medications were completed with the Administrator/Medication Technician (Med Tech). The Administrator/Med Tech provided R3 and R4's medications and the May 2024 Medication Administration Record which documented medications were administered by the facility for R3 and R4. On 05/07/24 in the afternoon, the Administrator confirmed the ultimate user agreement was not signed or dated by both parties for R3 and R4 and should have been. Severity: 2 Scope: 2	0876	1.Administrator made residents sign the ultimate user agreement the following day of inspection (5/9/2024). 2. Administrator will try to get all admission paperwork done upon admission to avoid any missing paperwork. Administrator to do monthly checks on resident's file to ensure completeness.	05/08/2024
0878 SS= F	Medication/OTCS, Supplements, Change Order - NAC 449.2742 and R043-22 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 5. An over-the-counter medication or a dietary supplement may be given to a resident only if the	0878	Ondansetron was delivered on 5/10/24 by Pharmacy. As for the oxycodone, prescription was then written by the provider to Pharmacy but the pharmacy did not have the oxycodone in stock. Prescription was then again transferred to St. Mary's another pharmacy which filled	08/29/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2788	A. BUILDING _____ B. WING _____	05/07/2024

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

(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
	resident's physician , physician assistant or advanced practice registered nurse has approved the administration of the medication or supplement in writing or the facility is ordered to do so by another physician, physician assistant or advanced practice registered nurse. The over-the-counter medication or dietary supplement must be administered in accordance with the written instructions of the physician, physician assistant or advanced practice registered nurse. The administration of over-the-counter medications and dietary supplements must be included in the record required pursuant to paragraph (b) of subsection 1 of NAC 449.2744. 6. Except as otherwise provided in this subsection, a medication prescribed by a physician, physician assistant or advanced practice registered nurse must be administered as prescribed by the physician, physician assistant or advanced practice registered nurse. If a physician, physician assistant or advanced practice registered nurse orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order; (2) Indicate on the container of the medication that a change has occurred; and (3) Note the change in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; (b) Within 5 days after the change is ordered, a copy of the order or prescription signed by the physician, physician assistant or advanced practice registered nurse must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; and (c) If the label prepared by a pharmacist does not match the order or prescription written by a physician, physician assistant or advanced practice registered nurse, a physician, registered nurse or pharmacist must interpret that order or prescription and, within 5 days after the change is ordered, the interpretation must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744. Inspector Comments: Based on record review and interview, the facility failed to		out the Oxycodone for resident #1. As soon as it was filled, administrator sent someone to pick Resident 1's oxycodone (Exhibit 2). PCP wrote for a lower dose and medication was delivered on 6/10/2023. None of the staff members has given any Tylenol to Resident #4. With regards to resident #3, New PCP discontinued the order of Tramadol q 6hrs PRN pain and changed it into Tramadol bid PRN pain (Exhibit 4). As for Resident #5, a discontinue order was written for Cetirizine, Lovastatin, and Nitrofurantoin. 2. When residents are out of their medication, administrator will continue reach out to health care providers (home health/hospice, PCP, & pharmacy) and bring residents to urgent care if they are willing and able to. Administrator will ensure that written prescription is to be followed by staff and that no medication administration changes will be made before acquiring the prescription change first.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2788	A. BUILDING _____ B. WING _____	05/07/2024

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

(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
	ensure: 1) medications were on site and available to be administered for 3 of 5 residents (Resident #1, #4, #5). 2) medications were administered as prescribed for 2 of 5 residents (Resident #1 and #3). 3) obtain a physician order, discontinue order or change order for 4 of 5 residents (Resident #1, #3, #4 and #5). 4) medications were secured for 1 of 5 Residents (Resident #1) and 5) PRN medications had a documented reason for use for 1 of 5 resident (Resident #3). Findings include: Resident #1 (R1) R1 was admitted on 05/03/23, with a diagnosis of Alzheimer's disease. A physician's order dated 05/06/23, and the medication bottle documented Hydrocodone 325 milligrams (mg). Take one tablet by mouth every four hours as needed for moderate pain. The medication bottle of Hydrocodone 325 mg with a dispense date of 04/24/24, and the label documented the bottle contained 45 pills when dispensed. The medication bottle was empty with no refill order or discontinue order on-site. The medication was not documented on the Medication Administration Record (MAR) as given in the month of April 2024 and May 2024. On 05/07/24, R1 had a bottle of Pepto Bismol at bedside. There was no physician's order for the medication and the medication was not listed on the May 2024 MAR. On 05/07/24 in the morning, R1 indicated they were in severe pain and had nausea. R1 reported they ran out of their Hydrocodone and Ondansetron approximately two weeks ago and were unable to pick up the refill due to a co-pay they were unable to afford. R1 was grimacing and holding their stomach and vomited during this interview. R1's Ondansetron was not on site and there was no physician's order in R1's file. The medication was not listed on the May 2024 MAR. On 05/07/24 in the afternoon, the Administrator indicated R1 had a new insurance company and was in the process of sending the prescription to a different pharmacy than they used before. The Administrator reported R1's Hydrocodone and Ondansetron ran out a couple of days ago but was uncertain of the exact day. The Administrator was unable to provide a physician's order for the Pepto Bismol and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2788	A. BUILDING _____ B. WING _____	05/07/2024

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

(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
	the Ondansetron and acknowledged Ondansetron should have been on site and the Pepto Bismol should have been secured. Resident #3 (R3) R3 was admitted on 09/28/23, with diagnosis including protein calorie malnutrition and acute renal failure. On 05/07/24 in R3's medication bin, a medication bottle documented Trazodone 50 mg, take one tablet by mouth every four hours PRN. There was no physician's order, and the medication did not document a reason for use. The May 2024 MAR documented Trazodone 50 mg. Take one tablet by mouth every night. The May 2024 MAR documented the medication was given routinely and not as needed as prescribed. On 05/07/24 in the afternoon, the Administrator reported R3 requested the Trazodone every day. The Administrator was unable to provide a change order for the medication to be administered routinely and did not recall if the medication had been changed. Resident #4 (R4) R4 was admitted on 05/02/23, with diagnosis including high blood pressure. On 05/07/24 in the morning, R4 reported they had back pain and had a pain level of 9 out of 10 and had run out of their Hydrocodone approximately two weeks ago. R4 was given Tylenol; however, it did not help the pain. On 05/07/24 in R4's medication bin a bottle documented Oxycodone-Acetaminophen 10-325 mg. Take one tablet by mouth four times per day. The bottle documented the medication was dispensed on 04/24/24 and contained 60 tablets when dispensed. The medication bottle was empty and according to the order on the label the medication should not have run out until 05/09/24. There was no physician's order, no refill on-site or discontinue order on site. On 05/07/24 in the afternoon, the Administrator acknowledged R4 should have had pills left in the bottle and sometimes the medication was given more than four times a day when the resident requested. The Administrator indicated the medication ran out a couple days ago but was unable to give an exact date. R4's file lacked documented evidence that the pain medication was given more than four times a day. Resident #5 (R5) R5 was admitted on 05/26/23, with diagnosis including			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2788	A. BUILDING _____ B. WING _____	05/07/2024

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

(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
	blindness and chronic back pain. The following medications were not on-site, had no physician's order, and were documented as given on the May 2024 MAR. Cetirizine 10 mg. Take one tablet by mouth every evening at 5:00 PM. Lovastatin 10 mg. Take one tablet by mouth every evening. Nitrofurantoin 50 mg. Take one capsule by mouth every day at 9:00 AM with food. On 05/07/24 in the afternoon, the Administrator indicated R5's Cetirizine, Lovastatin, and Nitrofurantoin were discontinued; however, was unable to provide documented evidence of a discontinued order. The Administrator acknowledged the medications were initialed as being administered on the May 2024 MAR as given and should not have been. Severity: 2 Scope: 3			
0895 SS= F	Administration of Medication Maintenance - NAC 449.2744 and R043-22 Administration of medication: Maintenance and contents of logs and records. (NRS 449.0302) 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall maintain: (b) A record of the medication administered to each resident. The record must include: (1) The type of medication administered; (2) The date and time that the medication was administered; (3) The date and time that a resident refuses, or otherwise misses, an administration of medication; (4) Instructions for administering the medication to the resident that reflect each current order or prescription of the resident's physician, physician assistant or advanced practice registered nurse, including, without limitation, whether the medication is to be administered according to a routine schedule or as needed; (5) Any change in an order or prescription of a resident ' s physician, physician assistant or advanced practice registered nurse,including, without limitation, the discontinuation of the medication; (6) Any time when the resident is out of the facility; and (7) Any mistakes made in the administration of medication. Inspector Comments: Based on interview, observation and record review, the facility	0895	1. As per pharmacy Hydrocodone was last filled 5/19/23. Hydrocodone was switched to Oxycodone on 5/23/23 and Oxycodone has been used by Resident#1 ever since her stay with the hospice (Exhibit 1). On 3/18/2024, hospice medical director wrote another prescription for Oxycodone (Exhibit 2) and this prescription was the one used to dispense the 45 pills on 4/24/24. The MAR reflecting the new written order for Oxycodone was made for Resident #1. As for Resident #3 PCP discontinued the order of Tramadol 50 mg tablet- 1 tab po q6hrs PRN pain because resident only asks for it twice daily. Staff still gives it twice daily but is now logging it in the PRN form reflecting the new order made by PCP on 5/10/24. The MAR reflecting discontinued medications for Resident #5 was made. Lovastatin was discontinued on 5/8/24 but was put back on 5/10/24. Caregiver copied MAR from previous month. 2. Findings were discussed with staff. Administrator will be more vigilant in checking the MAR. Administrator will be checking it at the beginning of every month and will ensure that the prescription, MAR, and medication bottle all match. Administrator will be the one responsible in communicating any changes made to the provider. Administrator also asked provider to communicate any changes made when	08/29/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2788	A. BUILDING _____ B. WING _____	05/07/2024

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

(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
	failed to ensure the Medication Administration Record (MAR) included accurate documentation for 3 of 5 residents' medications (Resident #1, #3 and #5). Findings include: Resident #1 (R1) R1 was admitted on 05/03/23, with a diagnosis of Alzheimer's disease. A physician's order dated 05/06/23, and the medication bottle documented Hydrocodone 325 milligrams (mg). Take one tablet by mouth every four hours as needed for moderate pain. The medication bottle of Hydrocodone with a dispense date of 04/24/24, and the label documented the bottle contained 45 pills when dispensed, and no refill order or discontinue order was on-site. The medication was not documented on the Medication Administration Record (MAR) as given in the month of April 2024 and May 2024. Resident #3 (R3) R3 was admitted on 09/28/23, with diagnosis including protein calorie malnutrition and acute renal failure. A physician's order dated 08/21/23, and the medication bottle documented Tramadol 50 mg, take one tablet by mouth every six hours as needed (PRN) for pain. The May 2024 MAR documented Tramadol 50 mg. Take one tablet by mouth two times a day. The May 2024 MAR documented the medication was given routinely and not as needed as prescribed. On 05/07/24 in the afternoon, the Administrator reported R3 requested the Tramadol every day. The Administrator was unable to provide a change order for the medications to be administered routinely and did not recall if the medications had been changed. Resident #5 (R5) R5 was admitted on 05/26/23, with diagnosis including blindness and chronic back pain. The following medications were not on-site, had no physician's order, and were documented as given on the May 2024 MAR. Cetirizine 10 mg. Take one tablet by mouth every evening at 5:00 PM. Lovastatin 10 mg. Take one tablet by mouth every evening. Nitrofurantoin 50 mg. Take one capsule by mouth every day at 9:00 AM with food. On 05/07/24 in the afternoon, the Administrator indicated R5's Cetirizine, Lovastatin, and Nitrofurantoin were discontinued; however, was unable to provide documented evidence of a discontinued order. The		sending electronic prescription to pharmacy. Pharmacy was asked to deliver electronic prescription together with new medicine.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2788	A. BUILDING _____ B. WING _____	05/07/2024

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

(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
	Administrator acknowledged the medications were initialed as being administered on the May 2024 MAR as given and should not have been. Severity: 2 Scope: 3			
0920 SS= F	Medication: Storage - NAC 449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. (NRS 449.0302) 1. Medication, including, without limitation, any over-the-counter medication, stored at a residential facility must be stored in a locked area that is cool and dry. The caregivers employed by the facility shall ensure that any medication or medical or diagnostic equipment that may be misused or appropriated by a resident or any other unauthorized person is protected. Medications for external use only must be kept in a locked area separate from other medications. A resident who is capable of administering medication to himself or herself without supervision may keep the resident ' s medication in his or her room if the medication is kept in a locked container for which the facility has been provided a key. 2. Medication stored in a refrigerator, including, without limitation, any over-the-counter medication, must be kept in a locked box unless the refrigerator is locked or is located in a locked room. Inspector Comments: Based on observation and interview, the facility failed to ensure resident medications were secured. Findings include: On 05/07/24 in the morning, there was a bottle of Pepto Bismol unsecured on Resident #1's night stand and Nystatin on Resident #2's bed side table. The residents did not self-administer medications. On 05/07/24 in the morning, Resident #1's medication bin was unsecured on the living room table and the medication cabinet was unsecured. On 05/07/24 in the morning, the Administrator confirmed the medications were unsecured and the facility administered Resident #1 and #2's medications. The Administrator acknowledged residents should not have medications at bedside. The Administrator indicated Resident #1's medications and the medication cabinet should have been locked. Severity: 2 Scope: 3	0920	1. All medication was secured during inspection. (5/7/2023). 2. Administrator explained to resident that all OTC medicine needs a written order from their PCP and must be secured in the facility's medication cart or have their own personal locked containers if keeping their own meds. Staff are told to lock all medication once done administering. Caregivers to do a bedside check for unprescribed medications used by residents.	08/29/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2788	A. BUILDING _____ B. WING _____	05/07/2024

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

(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
0936 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: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. Inspector Comments: Based on record review and interview, the facility failed to ensure 3 of 5 residents (Resident #1, #4, and #5) received a two-step tuberculosis (TB) test. Findings include: Resident #1 (R1) R1 was admitted on 05/03/23, with a diagnosis of Alzheimer's disease. R1's file lacked documented evidence of a two-step TB test. Resident #4 (R4) R4 was admitted on 05/02/23, with diagnosis including high blood pressure. R4's file lacked documented evidence of a two-step TB test. Resident #5 (R5) R5 was admitted on 05/26/23, with diagnosis including blindness and chronic back pain. R5's file lacked documented evidence of a two-step TB test. On 05/07/24 in the morning, the Administrator acknowledged the resident files lacked documented evidence of a two-step TB test, completed per the requirement. Severity: 2 Scope: 3	0936	1. Copy of initial TB tests for three residents were requested by administrator from provider (5/7/2) and annual TB test for residents 1 and 4 were administered the following day (5/8/23). 2. Administrator will not accept resident with incomplete admission paperwork and will check resident files monthly to ensure all necessary tests and procedures be done for residents.	05/10/2024
0938 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	0938	1. ADL assessments were requested and completed the following day of inspection (5/8/2024). 2. Administrator will make sure that ADL form is included in the admission packet to ensure that initial ADL is made. Administrator will also ensure that ADL is done yearly by checking resident files monthly or made whenever a mental or physical change occurs.	05/08/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2788	A. BUILDING _____ B. WING _____	05/07/2024

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

(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
	related to the resident, including, without limitation: (g) An evaluation of the resident ' s ability to perform the activities of daily living and a brief description of any assistance he or she needs to perform those activities. The facility shall prepare such an evaluation: (1) Upon the admission of the resident; (2) Each time there is a change in the mental or physical condition of the resident that may significantly affect his or her ability to perform the activities of daily living; and (3) In any event, not less than once each year. Inspector Comments: Based on record review and interview, the facility failed to ensure an Activities of Daily Living (ADL) Assessment was completed initially and/or annually for 5 of 5 residents (Resident #1, #2, #3, #4, and #5). Findings include: Resident #1 (R1) R1 was admitted on 05/03/23, with a diagnosis of Alzheimer's disease. R1's file revealed an undated ADL Assessment and lacked documented evidence of a signed and dated initial and annual ADL assessment. Resident #2 (R2) R2 was admitted on 08/22/23, with diagnosis including anxiety, cellulitis, and depression. R2's file lacked documented evidence of an initial ADL assessment. Resident #3 (R3) R3 was admitted on 09/28/23, with diagnosis including protein calorie malnutrition and acute renal failure. R3's file lacked documented evidence of an initial ADL assessment. Resident #4 (R4) R4 was admitted on 05/02/23, with diagnosis including high blood pressure. R4's file lacked documented evidence of an initial and annual ADL assessment. Resident #5 (R5) R5 was admitted on 05/26/23, with diagnosis including blindness and chronic back pain. R5's file lacked documented evidence of an initial ADL assessment. On 05/07/24 in the morning, the Administrator acknowledged the resident files lacked documented evidence of a completed initial and/or annual ADL Assessment and was unable to provide the missing documents. Severity: 2 Scope: 3			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2788	A. BUILDING _____ B. WING _____	05/07/2024

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

(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
0991 SS= F	Alzheimer 's Care Standards for Safety - NAC 449.2756 and R043-22 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 or other forms of dementia who meet the criteria prescribed in paragraph (a) of subsection 2 of NRS 449.1845 shall ensure that: (b) Operational alarms, buzzers, horns or other technology for notifying staff 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 3 of 4 exit doors had operational alarms. Findings include: On 05/07/24 in the morning, the alarms were turned off on two sliding glass doors leading to the backyard and the door leading to the garage. The Administrator turned the alarms back on and at 1:30 PM the alarm on the sliding glass door in the living room was turned off a second time. On 05/07/24 in the morning, the Administrator acknowledged the alarms were turned off and should have been left on. Severity: 2 Scope: 3	0991	1. Alarms were turned on by the administrator during inspection (5/7/2024). Other caregiver acknowledged to turning it off so as not to wake up the residents early in the morning and to prevent the noise during inspection as 2 of the residents go out in the backyard a lot for smoke. 2. Administrator stressed to staff the importance of having the alarms turned on at all times for safety of residents. Administrator to monitor for compliance.	05/07/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2788	A. BUILDING _____ B. WING _____	05/07/2024

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

(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
0994 SS= F	Alzheimer 's Care Standards for Safety - NAC 449.2756 and R043-22 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 or other forms of dementia who meet the criteria prescribed in paragraph (a) of subsection 2 of NRS 449.1845 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 objects were not accessible to residents. Findings include: On 05/07/24 in the morning, there was a pair of scissors on the kitchen counter, three sharp knives in the drying rack on the kitchen counter, a kitchen drawer containing several knives was unsecured, and there was a pair of cutical cutters on the resident's bedside table in the room next to the kitchen. On 05/07/24 in the morning, the Administrator acknowledged the knives, cutical cutter, and scissors were unsecured and should have been locked. This was a repeat deficiency from the 10/10/23 State Licensure survey. Severity: 2 Scope: 3	0994	1. Scissors and knives were secured during inspection and cuticle remover secured after inspection (5/7/24). 2. Staff are to secure sharps as soon as possible. Instead of air drying, staff will wipe dry all sharps and secure it right away. Administrator spoke to resident regarding keeping the cuticle cutter locked in the med cart and giving it to her when she wants to use it. Resident agreed. Administrator to monitor for compliance.	05/07/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2788	A. BUILDING _____ B. WING _____	05/07/2024

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

(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 and R043-22 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 or other forms of dementia who meet the criteria prescribed in paragraph (a) of subsection 2 of NRS 449.1845 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 secured. Findings include: On 05/07/24 in the morning, there was unsecured laundry soap, bleach, window cleaner, and multipurpose cleaner in the garage. The door leading to the garage was unlocked and the key was left in the lock. On 05/07/24 in the morning, the Administrator acknowledged the unsecured toxic substances and reported it should have been locked. Severity: 2 Scope: 3	0999	1. Key to garage door was taken out during inspection (5/7/24). One of the caregivers was doing laundry prior to inspector arriving and left the key for the ease of getting in and out the garage. 2. Administrator stressed the importance of keeping the garage door locked at all times to prevent the residents from going in there and having access to chemicals.	05/07/2024
1540 SS= D	Cultural Competency Training - Cultural Competency Training R016-20 Sec. 14 1. Pursuant to subsection 1 of NRS 449.103, within 30 business days after the course or program is assigned a course number by the Division pursuant to section 18 of this regulation or within 30 business days of any agent or employee being contracted or hired, whichever is later, and at least once each year thereafter, a facility shall conduct training relating specifically to cultural competency for any agent or employee of the facility who provides care to a patient or resident of the facility so that the agent or employee may: (a) More effectively treat patients or care for residents, as applicable; and (b) Better understand patients or residents who have different cultural backgrounds, including, without limitation, patients or residents who fall within one or more of the categories in paragraphs (a) to (f), inclusive, of subsection 1 of NRS 449.103. R016-20 Sec. 14 2. The facility shall provide the training required by subsection 1 through a course or program that is approved by the Director of the	1540	1. Employee 4's Cultural Competency Training dated January 28, 2023 was placed in caregiver's folder. 2. Administrator will review employee file monthly to ensure that it is complete.	06/14/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2788	A. BUILDING _____ B. WING _____	05/07/2024

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

(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
	Department or his or her designee pursuant to section 17 of this regulation and is assigned a course number by the Division pursuant to section 18 of this regulation. R016-20 Sec. 14 3. The facility shall keep documentation in the personnel file of any agent or employee of the facility of the completion of the cultural competency training required pursuant to subsection 1. R016-20 Sec. 15 1. Within 90 days after a facility is licensed to operate, the facility must submit to the Department on a form prescribed by the Department the course or program which the facility will use to provide cultural competency training. The facility may: (a) Develop or operate the course or program; or (b) Contract with a third party to develop and operate the course or program. R016-20 Sec. 15 2. The course or program submitted by the facility pursuant to subsection 1 must address patients or residents who have different cultural backgrounds from that of the agent or employee of the facility, including, without limitation, patients or residents who fall within one or more of the categories in paragraphs (a) to (f), inclusive, of subsection 1 of NRS 449.103. R016-20 Sec. 15 3. When a facility submits a course or program pursuant to subsection 1, the facility must also provide to the Department the following information for the instructor of the course or program: (a) The application of the instructor who will teach the course or program; (b) Three letters of recommendation for the instructor, including, without limitation, at least one letter of recommendation in which the recommender has knowledge of the methods the instructor uses in teaching a cultural competency course or program; and (c) The resume of the instructor of the course or program that includes, without limitation, the education, training and experience the instructor has in providing cultural competency training. R016-20 Sec. 15 4. Except as otherwise provided in subsection 5, when a facility submits a course or program pursuant to subsection 1, the facility must also provide to the Department: (a) The syllabus of the course or program; (b) The following information: (1) The name of the facility; (2) The address			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2788	A. BUILDING _____ B. WING _____	05/07/2024

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

(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
	of the facility; (3) The electronic mail address of the facility; (4) The license number of the facility; and (5) The name and contact information of a person who represents the facility and who can discuss the course or program submitted by the facility pursuant to subsection 1; (c) If the facility contracts with a third party who develops and operates the course or program, the following information: (1) The name of the third party; (2) The address of the third party; (3) The electronic mail address of the third party; and (4) The name and contact information of a person who represents the third party and who can discuss the course or program submitted by the facility pursuant to subsection 1; (d) Evidence that the subjects covered by the course or program include, without limitation, the course materials required by section 16 of this regulation; (e) A sample sign-in sheet for the course or program that contains: (1) The dates of the course or program; and (2) A place for a participant of the course or program to print and sign his or her name; (f) A sample evaluation form that a participant of the course or program may complete at the end of the course or program which evaluates: (1) The content of the course or program; (2) The instructor of the course or program; and (3) The manner in which the course or program is presented to the participant; and (g) A sample document that a participant of the course or program may complete at the end of the course or program in which the participant can perform a self-evaluation. R016-20 Sec. 15 5. A facility may submit a course or program pursuant to subsection 1 without submitting the information required in subsection 4 if the course or program: (a) Is provided by: (1) A nationally recognized organization, as determined by the Director of the Department; (2) A federal, state or local government agency; or (3) A university or college that is accredited in the District of Columbia or any state or territory of the United States; and (b) Provides proof of completion upon the participant of the course or program completing the course or program that the Director or his or her designee determines to be satisfactory. R016-20 Sec. 15 6. When a facility submits			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2788	A. BUILDING _____ B. WING _____	05/07/2024

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

(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
	pursuant to subsection 1 a course or program that is described in subsection 5, the facility must also provide to the Department: (a) The name of the course or program; (b) The name of the organization, agency, university or college providing the course or program; (c) If the course or program is provided online, the URL of the course or program; (d) If the course or program is provided through a training system, access to the training system; (e) If the course or program is not provided online or through a training system, the syllabus of the course or program; (f) The following information: (1) The name of the facility; (2) The address of the facility; (3) The electronic mail address of the facility; (4) The license number of the facility; and (5) The name and contact information of a person who represents the facility and who can discuss the course or program submitted by the facility pursuant to subsection 1; and (g) Any other information the Department requests to assist the Director or his or her designee in determining whether or not to approve the course or program pursuant to section 17 of this regulation. 7. As used in this section, "URL" means the Uniform Resource Locator associated with an Internet website. R016-20 Sec. 16 1. A course or program subject to the requirements of subsection 4 of section 15 of this regulation must include, without limitation, the following course materials: (a) An overview of cultural competency; (b) An overview of implicit bias and indirect discrimination; (c) The common assumptions and myths concerning stereotypes and examples of such assumptions and myths; (d) An overview of social determinants of health; (e) An overview of best practices when interacting with persons who fall within one or more of the categories in paragraphs (a) to (f), inclusive, of subsection 1 of NRS 449.103; (f) An overview of gender, race and ethnicity; (g) An overview of religion; (h) An overview of sexual orientation and gender identities or expressions; (i) An overview of mental and physical disabilities; (j) Examples of barriers to providing care; (k) Examples of language and behaviors that are discriminatory; and (l) Examples of a			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2788	A. BUILDING _____ B. WING _____	05/07/2024

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

(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
	welcoming and safe environment. R016-20 Sec. 16 2. The course materials included in a course or program, including, without limitation, the course materials required by subsection 1, must include, without limitation: (a) Evidence-based, peer-reviewed sources; (b) Source materials that are used in universities or colleges that are accredited in the District of Columbia or any state or territory of the United States; (c) Source materials that are from nationally recognized organizations, as determined by the Director of the Department; (d) Source materials that are published or used by federal, state or local government agencies; or (e) Other source materials that are deemed appropriate by the Department. R016-20 Sec. 17 4. The facility shall submit the additional information that the facility needs to submit pursuant to paragraph (b) of subsection 3 within 45 days after being notified that the course or program is not approved pursuant to paragraph (a) of subsection 3. Upon receiving the additional information, the Director or his or her designee may approve the course or program. If the additional information is not received or fails to include all of the information that the Director or his or her designee informed the facility that it needed to submit, the Director or his or her designee shall not approve the course or program. Inspector Comments: Based on record review and interview, the facility failed to ensure 1 of 4 employees received cultural competency training through a Bureau approved course (Employee #4). Findings include: Employee #4 (E4) was hired on 07/18/17, as a Caregiver. E4's file lacked documented evidence of cultural competency training completed through a Bureau approved course. On 05/07/24 in the afternoon, the Administrator acknowledged E4's file lacked documented evidence of cultural competency training and was unable to provide the missing document. Severity: 2 Scope: 1			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2788	A. BUILDING _____ B. WING _____	05/07/2024

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

(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
1840 SS= E	UNL Caregiver Training - R063-21 Sec. 4 1. An unlicensed caregiver who provides care to residents, patients or clients at a facility described in section 3 of this regulation shall annually complete evidence-based training provided by a nationally recognized organization concerning the control of infectious diseases. The training must include, without limitation, instruction concerning: (a) Hand hygiene; (b) The use of personal protective equipment, including, without limitation, masks, respirators, eye protection, gowns and gloves; (c) Environmental cleaning and disinfection; (d) The goals of infection control; (e) A review of how pathogens, including, without limitation, viruses, spread; and (f) The use of source control to prevent pathogens from spreading. 2. Each unlicensed caregiver who completes the training required by subsection 1 must provide proof of completion of that training to the administrator or other person in charge of the facility in which the unlicensed caregiver provides care. Inspector Comments: Based on record review and interview, the facility failed to ensure 2 of 4 employees (Employees #1 and #4) acquired the required infection control training. Findings include: The following employee files lacked documented evidence infection control training was completed through a nationally recognized course. Employee #1 was hired on 03/25/99, as a Caregiver. Employee #4 was hired on 7/18/07, as a Caregiver. On 05/07/24 in the afternoon, the Administrator acknowledged the employees did not receive infection control training through a nationally recognized course. Severity: 2 Scope: 3	1840	1. Caregivers 1 & 4 completed the training on 6/14/24. 2. Administrator will require all caregivers to complete Infection Control training upon hire and annually from a nationally recognized provider thereafter. Administrator will be responsible for checking employee files monthly to ensure that this training is complete and up to date.	06/14/2024