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 _____	05/27/2025

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 an annual state licensure survey completed at your facility on 05/27/25, 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 six. Six resident files and four employee files were reviewed. The facility received a grade of C. 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		
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 05/27/25 in the morning, the common area of the facility was cluttered with various boxes and bags of unknown personal belongings or items that were stacked on the couches so residents and visitors could not sit or do activities. There was one resident seated in a wheelchair because there was nowhere to sit on the couch or chairs due to the clutter. The common area contained a desk, office equipment, personal items and paperwork that were located on top of the desk and other items cluttering the room. The floor throughout the facility was cluttered with bags filled with unknown items and other debris making it difficult to gain proper access to the garage	0178	1. a) -Clutter of boxes and bags were temporarily stored in the north side yard (5/31/25). The clutter was due to the freeway widening project; the items were removed from the shed before it was partially cut in half to make space for their safety barrier. A storage was rented (7/13/2025) (Exhibit 1) on a monthly basis when the facility found out that the crew will not reassemble the shed until the completion of their project. -Outlet covers were acquired and utilized. Outlets were cleaned.(Exhibit 2) -Dining room table was cleared. Only one resident regularly eats in the bedroom because she can not remain seated upright. The residents who were a couple started eating in the room when the male resident started to decline and his partner chose to eat with him in their room. Prior to that they have always eaten in the dining room. The remaining three residents have always been eating their meals in the dining room. Facility encourages residents to eat in the dining room but respects their preference if they choose not to do so. -The kitchen counter was cleared and cleaned when preparing the next meal	08/04/2025

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	and the laundry facilities. Outlets throughout the facility were missing outlet covers and were soiled with unknown substances or heavy dust build-up. The dining room table was cluttered with mail, office supplies and other assorted items which prevented residents to eat at the table. Most of the residents indicated they would eat in their rooms during mealtimes. The residents who could go outside would eat on the table on the backyard patio. 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. A bathroom had a used adult incontinence undergarment on the ground beside the toilet. The patio in the backyard was cluttered with one small pile and one large pile of boxes and bags of various staff personal items, resident incontinence or personal hygiene supplies, cleaning or kitchen items. The table on the backyard patio was cluttered with various kitchen and other items. The walkway to the shed was cluttered with kitchen supplies and various types of medical equipment. On 05/27/25 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 05/07/24 annual survey. Severity: 2 Scope: 3		(5/27/25) (Exhibit 3). -The clutter from the patio backyard, table, walkway to the shed all came from the dismantled shed. They were also temporarily moved in the north side yard (5/31/2025) until a storage unit was rented (7/13/2025). b) Facility will remain clutter-free by relocating shed items to a storage facility and implementing new systems of organization to reduce the presence of unnecessary items throughout the facility and keep the necessary items stored properly. Administrator sourced additional assistance to maintain organization. Administrator is responsible for this oversight.	
0690 SS= F	Residents Requiring Use of Oxygen - NAC 449.2712 Residents requiring use of oxygen. (NRS 449.0302) 1. A person who requires the use of oxygen must not be admitted to a residential facility or be permitted to remain as a resident of a residential facility unless he or she: (a) Is mentally and physically capable of operating the equipment that provides the oxygen; or (b) Is capable of: (1) Determining his or her need for oxygen; and (2) Administering the oxygen to himself or herself with assistance. 2. The caregivers employed by a residential facility with a resident who requires the use of oxygen shall: (a) Monitor the ability of the resident to operate the equipment in accordance	0690	2) a) -During the time of survey, there is one signage regarding oxygen use and it is located outside, on the left side of the entrance doorway(Exhibit 5a). After the survey (6/7/25) additional signage was added inside- the hallway leading to the patient's room using oxygen (Exhibit 5b), living room (Exhibit 5c), and by the dining area (Exhibit 5d). Caregiver moved out the tanks since the medical equipment company nor hospice didn't come pick it up. -Deficient practice will no longer occur as signage will be left posted on the wall. Facility is ultimately responsible for disposing oxygen tanks when vendor or healthcare provider does not respond to facility's request for oxygen pickup.	08/04/2025

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	with the orders of a physician; and (b) Ensure that: (1) The resident ' s physician evaluates periodically the condition of the resident which necessitates his or her use of oxygen; (2) Signs which prohibit smoking and notify persons that oxygen is in use are posted in areas of the facility in which oxygen is in use or is being stored; (3) Persons do not smoke in those areas where smoking is prohibited; (4) All electrical equipment is inspected for defects which may cause sparks; (5) All oxygen tanks kept in the facility are secured in a stand or to a wall; (6) The equipment used to administer oxygen is in good working condition; (7) A portable unit for the administration of oxygen in the event of a power outage is present in the facility at all times when a resident who requires oxygen is present in the facility; and (8) The equipment used to administer oxygen is removed from the facility when it is no longer needed by the resident. Inspector Comments: Based on observation and interview, the facility failed to ensure 1) there was appropriate signage identifying the storage of oxygen tanks and prohibiting smoking; 2) oxygen tanks were properly secured within the facility and 3) equipment used to administer oxygen was removed from the facility when it was no longer needed. Findings include: On 05/27/25 in the morning, two oxygen (O2) tanks were in the facility's garage/laundry area. The third O2 tank was discovered outside beside the facility shed exposed to the heat and elements. The three O2 tanks had none of the required signage to identify the storage of the oxygen tanks or to prohibit smoking. The equipment used to administer the oxygen was not removed from the facility as it was verified at the survey residents requiring the oxygen had either passed away or had moved. On 05/27/25 in the morning, the Administrator and Caregiver acknowledged the oxygen tanks were not properly stored with the appropriate signage. The Administrator and Caregiver acknowledged the equipment used to administer the oxygen was no longer needed and should have been removed from the facility. Severity: 2 Scope: 3		Disposal has to be done within a week of disposal request. Administrator is responsible for this oversight.	

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0920 SS= D	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 05/27/25 in the morning, observed on top of an unlocked medicine cabinet were medications in small containers. The medications remained unsecured for 4 1/2 hours. On 05/27/25 in the morning, there was a bottle of Nystatin on Resident #2's bed side table. The residents in this shared room did not self-administer medications. On 05/27/25 in the morning, the Administrator confirmed the medications observed were unsecured and the facility administered Resident #2's medications. The Administrator acknowledged residents should not have medications at the bedside or unsecured in the facility. This was a repeat deficiency from the 05/07/24 annual survey. Severity: 2 Scope: 1	0920	1a) Medication was administered when it was time for it to be administered and medication cabinet was locked after (5/27/25). For ease of locking, medication cabinet with keyed padlock was switched to biometric fingerprint cabinet lock accessible only to staff (Exhibit 6). Nystatin was locked in the medication cabinet (5/27/25). b) Administrator told caregivers to prepare the medication only when its time for them to take their medication. Administrator will monitor for compliance.	08/04/2025

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0923 SS= F	Medication: Storage - NAC 449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. (NRS 449.0302) 3. Medication, including, without limitation, any over-the-counter medication or dietary supplement, must be: (a) Plainly labeled as to its contents, the name of the resident for whom it is prescribed and the name of the prescribing physician; and (b) Kept in its original container until it is administered. Inspector Comments: TAG 923 Based on observation and interview, the facility failed to ensure medications were not pre-poured prior to administration. Findings include: On 05/27/25 in the morning, observed on top of an unlocked medicine cabinet were medications in small containers. The medications remained unsecured for 4 1/2 hours. On 05/27/25 in the morning, the Administrator and Caregiver indicated they pre-poured medications, into medication cups, for all residents, and set them on top of the medicine cabinet. The Administrator and Caregiver confirmed the medications were not kept in the original containers until the time of administration. Severity: 2 Scope: 3	0923	1. a) Medication was given to residents when it was time for it to be administered (5/27/2025). b) Administrator told caregivers to prepare medications only when its time for it to be administered. Administrator will monitor for compliance.	08/04/2025

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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 an audible alarm was activated on 3 of 5 doors exiting the facility. Finding include: On 05/27/25 in the morning, a tour of the facility revealed the audible alarm on three exit doors, leading respectively to the laundry area, the garage and the backyard were not activated. On 05/27/25 in the morning, the Administrator and Caregiver acknowledged the alarms were not turned on. This was a repeat deficiency from the 05/07/24 annual survey and 10/17/24 grading resurvey. Severity: 2 Scope: 3	0991	1. a) Alarms leading to the laundry area, garage, and backyard were turned on (5/27/2025). b) Administrator told caregivers not to turn off alarms. Administrator will monitor for compliance.	08/04/2025

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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 05/27/25 in the morning, there was a stapler, letter opener, a shaving razor and pair of scissors observed unsecured on a table located in the common area. On 05/27/25 in the morning, on the ground beside the facility's outdoor shed was a kitchen drawer container with a pizza cutter, can opener, nine knives and a meat cleaver. On 05/27/25 in the morning, the Administrator acknowledged the sharp items were all unsecured and should have been locked. This was a repeat deficiency from the 05/07/24 annual survey. Severity: 2 Scope: 3	0994	1.a)- Stapler, letter opener, shaving razor, and pair of scissors were secured from the common area table (Exhibit 9) . -Pizza cutter, can opener, knives, and meat cleaver beside the shed were secured in the storage (Exhibit 10). b) Administrator told caregivers to secure items used that could be dangerous to residents. Administrator will monitor for compliance	08/04/2025

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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 05/27/25 in the morning, observed were unsecured antiseptic wipes, glue, liquid paper and other craft adhesives on the dining room and common area tables. On 05/27/25 in the morning, the facility's outdoor shed was unlocked and the doors were open. Inside the shed were paints, cleaning solvents and other unknown liquid chemicals. On 05/27/25 in the afternoon, the Administrator acknowledged the toxic substances were unsecured and reported they should have been locked. This was a repeat deficiency from the 05/07/24 annual survey. Severity: 2 Scope: 3	0999	1. a)-Antiseptic wipes, glue, liquid paper, and craft adhesives from the dining area and common area tables were secured (5/27/2025) . -Outdoor shed containing paints, cleaning solvents, and chemicals was locked (5/27/2025). b) Administrator told caregivers to secure all potentially dangerous items after each use for safety of residents and that outdoor shed will be locked immediately after taking items from it. Administrator will monitor for compliance.	08/04/2025