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 _____	06/03/2026

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
RFG 0001-Deficiencies	The Statement of Deficiencies was generated as a result of a state licensure survey conducted in your facility, in accordance with Nevada administrative code, chapter 449, and Nevada revised statutes chapter 449- Residential Facility for Groups (RFG), medical facilities and other related entities. The findings and conclusions of any investigation by the Division of Health Care Purchasing and Compliance shall not be construed as prohibiting any criminal civil investigation, actions or other claims for reliefs that may be available to any party under applicable federal, state or local law. Based on an inspection conducted, the items marked below identify the violation in operation of the RFG which must be corrected by the revisit/compliance date specified in writing by the health authority. Failure to comply with this notice and immediately correct the identified deficiencies may result in the suspension or termination of your provider agreement, funding, or future authorization as a provider authorized by the State	RFG 0001-Deficiencies		

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	of Nevada pursuant to NAC 433.384, and other applicable local and state laws. Inspector Comments: This Statement of Deficiencies was generated as a result of an annual survey completed at your facility on 06/03/26. The facility is licensed for seven Residential Facility for Group beds for elderly and disabled persons and/or 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 A.			
Y 0890 SS= D	NAC 449.2744 **Administration of medication: Maintenance of logs and records; contents.** 1. The administration of a residential facility that provides assistance to residents in the administration of medications shall maintain: (a) A log for each medication received by the facility for use by a resident of the facility. The log must include: (1) The type and quantity of medication received by the facility; (2) The date of its delivery; (3) The name of the person who accepted the delivery; (4) The name of the resident for whom the medication is prescribed; and (5) The date on which any unused medication is removed from the facility or destroyed. (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;	Y 0890	1) Medication was logged by caregiver on the MAR and patient was notified that his PRN medication is available after inspection took place(6/3/26). On 6/2/26 the medication was delivered and received by the caregiver. The caregiver did not log it on the MAR right away because she was in the middle of helping another resident schedule a doctor's appointment. Administrator reminded caregiver to log the medication in the MAR after helping the other resident. 2) Administrator spoke to caregiver after inspection and reiterated to caregiver that whoever receives the medication is the one responsible for logging it in the MAR and notifying the patient. Administrator stressed the importance of immediate logging in the MAR for newly delivered medications to avoid forgetting its documentation and facilitate timely dispensing to the patient. Administrator will monitor and is responsible for reinforcing compliance.	08/18/2026

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	(3) The date and time that a resident refuses, or otherwise misses, an administration of medication; and (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. (Cross-reference to NAC 449.2742(5)) 2. The administrator of the facility shall keep a log of caregivers assigned to administer medications that indicates the shifts during which each caregiver was responsible for assisting in the administration of medication to a resident. This requirement may be met by including on a resident's medication sheet an indication of who assisted the resident in the administration of the medication, if the caregiver can be identified from this indication. Inspector Comments: Based on observations, interviews, and record review the facility failed to ensure a medication was administered for 1 of 5 sampled residents (Resident #1). Resident #1 (R1) R1 was admitted to the facility on 03/27/26 with a diagnosis of depression. A physician's order for R1 dated 06/01/26, documented Ondansetron 4 milligrams (mg) take one tablet by mouth as needed for			

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	nausea. On 06/03/26 in the morning, the medication Ondansetron was observed in R1's medication bin but the medication was not documented on R1's Medication Administration Record (MAR) and R1's record lacked documented evidence the medication was administered. On 06/03/26 at 10:19 AM, R1 indicated feeling nauseous for the past few days and verbalized the medication for nausea was not administered, because the staff did not offer it. On 06/03/26 in the morning, the Caregiver indicated forgetting to document the medication Ondansetron 4 mg on R1's MAR and verbalized one of the Caregiver's should have asked R1 if they were having symptoms of nausea so the medication could have been administered. Severity: 2 Scope: 1			