

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295008	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER El Jen Skilled Care		STREET ADDRESS, CITY, STATE, ZIP CODE 5538 W Duncan Dr Las Vegas, NV 89130	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46265</p> <p>Based on interviews, record review, and document review the facility failed to ensure abuse policies and procedures were implemented for 1 of 5 sampled residents. The deficient practice had the potential to put residents at risk of negative physical or psychosocial outcomes.</p> <p>Findings include:</p> <p>Resident 3 (R3)</p> <p>R3 was admitted on [DATE] and readmitted on [DATE] with diagnoses including anxiety, mood disorder, and unspecified psychosis.</p> <p>A facility report indicated a Certified Nursing Assistant (CNA1) was walking past room of R3 where another Certified Nursing Assistant (CNA2) was providing care to the resident. CNA1 reported hearing a noise which sounded like a hand slapping against skin or body part.</p> <p>The facility investigation documented CNA1 walked past room and had concern CNA2 was being physically abusive to R3, however did not intervene to stop the alleged abuse. CNA1 walked past the resident's room and directly to the charge nurse to report suspected abuse.</p> <p>The witness statements from CNA1 confirmed CNA1 did not actually see any physical abuse only heard sounds which raised concern. CNA1 did not enter room and intervene.</p> <p>On 05/16/2024 in the afternoon, a CNA indicated if there was suspected abuse the first priority was to ensure resident safety and intervene and then contact the abuse coordinator.</p> <p>On 05/16/2024 in the afternoon, a Licensed Practical Nurse (LPN) verbalized for any suspected physical abuse the goal was to first ensure resident safety and contact the abuse coordinator. The LPN indicated CNA1 did not follow facility protocol by not intervening to determine if abuse was occurring and then contact the abuse coordinator.</p> <p>On 05/16/2024 at 11:03 AM, a Licensed Social Worker (LSW) who was familiar with the incident indicated during the investigation the facility staff did a reenactment of the situation and found when walking past the room with the way the incident was described, it would be nearly impossible to see the interaction between staff member and resident. The LSW explained someone walking past a room would need to enter the room to see the upper part of the body of staff member at bedside.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The LSW verbalized the action of CNA1 did not meet facility expectations as it would be expected to have staff member intervene and stop any abuse occurring and then contact the abuse coordinator.</p> <p>On 05/16/2024 in the afternoon, CNA1 indicated no physical abuse was observed only movement from CNA2 and then hearing what sounded like someone getting slapped in the face. CNA1 verbalized being shocked and did not know what to do and went directly to the charge nurse.</p> <p>On 05/16/2024 at 2:32 PM, the Director of Nursing (DON) indicated the expectation from staff would be to intervene and stop abuse to ensure resident safety and then contact the abuse coordinator. The DON acknowledged CNA1 did not intervene and walked past where suspected abuse was occurring and directly to the charge nurse to report.</p> <p>Employment training records indicated CNA1 was up to date on abuse training.</p> <p>A facility document for testing to ensure comprehension of abuse policy and procedure documented the first step to take was to intervene and stop suspected abuse.</p> <p>The facility policy titled Resident Rights documented all residents would be free from abuse, neglect, misappropriation of property, and exploitation.</p> <p>Complaint NV00070508</p> <p>FRI NV00070059</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40131</p> <p>Based on observation, interviews, record reviews, and document reviews, the facility failed to ensure an incident in which an elderly resident with dementia and Alzheimer's disease was forced to take medications was promptly reported to the abuse coordinator and the agency within the mandated timeframes for 1 of 5 sampled residents (Resident 5). This deficient practice had the potential to lead to unaddressed abuse and compromise the resident's health and well-being.</p> <p>Findings include:</p> <p>Resident 5 (R5)</p> <p>R5 was admitted on [DATE], with diagnoses including Alzheimer's disease and dementia.</p> <p>The Minimum Data Set, dated dated dated [DATE], documented a brief interview of mental status score of 99, which indicated the interview had not been completed due to impairment of R5's cognitive status.</p> <p>A Care Plan dated 09/22/2022, documented R5 had episodes of resistance to care during the medication pass. The interventions included re-approaching R5 calmly, redirecting behavior, and re-offering medication.</p> <p>The facility report dated 02/01/2024, documented the alleged incident occurred on 01/06/2024, a Certified Nursing Assistant 2 (CNA2) witnessed another Certified Nursing Assistant 1 (CNA1) standing behind and holding the head of R5 while a Licensed Practical Nurse 1 (LPN1) held R5's cheeks and forced R5 to take the medication.</p> <p>The facility investigation notes dated 01/16/2024, documented R5's family was interviewed by the Director of Nursing (DON) and the family reported previously witnessing LPN1 who forced R5 to take the medications in two incidents. The family stated LPN1 was advised to stop forcing R5 to take the medications and return later. The family ended up giving R5's medications.</p> <p>On 05/16/2024 at 8:29 AM, the Director of Human Resources (DHR), indicated CNA1 and CNA2 were still employed at the facility. LPN1 resigned on 02/01/2024.</p> <p>On 05/16/2024 at 8:48 AM, a Licensed Practical Nurse 2 (LPN2) assigned to R5 in the secured unit indicated R5's medications were crushed and mixed with pudding. R5 took the medication without any resistance. The LPN indicated R5 was verbally alert times one, had confusion, and was exhibiting resistive care behavior.</p> <p>LPN2 indicated when R5 refused the medication, it would be re-offered and if still refused, to notify the physician and document. LPN2 indicated was familiar with R5, and the medications would have been administered when R5 was eating because R5 was in a good mood. LPN2 stated forcing medications on the resident would constitute abuse. LPN2 began employment at the facility in November 2024, confirming the last abuse training had been completed.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 05/16/2024 at 9:04 AM, R5 was seated in bed, pleasant, and verbally responsive with confusion. When asked about any incident where staff members forced R5 to take the medications, R5 replied, I don't know. When asked if there was any concern regarding the care, R5 replied, Yes. R5 did not respond with follow-through questions.</p> <p>On 05/16/2024 at 9:15 AM, the Physician Assistant (PA) indicated if a resident had dementia and Alzheimer's disease and refused the medications, the staff were expected to keep trying, but the medications could not be forced. If a resident kept refusing and was unable to administer the medications, the process was to re-offer, notify the provider, family, and document.</p> <p>On 05/16/2024 at 10:02 AM, the Director of Social Services (DSW) indicated R5's family had previously witnessed the LPN forcing R5 to take the medications. The DSW indicated the incident was reported to the state on 02/01/2024 and finalized the report on 02/05/2024. The incident was substantiated when LPN1 forced the medication on R5 with three eyewitnesses. The DSW confirmed there was a delay in the investigation and reporting to the state agency when the incident occurred on 01/06/2024. The DSW indicated the staff had received abuse training.</p> <p>The Nursing Assignment dated 01/06/2024 (Saturday), revealed LPN1, CNA1 and CNA2 were assigned to the secured unit during the day shift.</p> <p>On 05/16/2024 at 12:43 PM, during a telephone interview, CNA2 who witnessed the incident recounted approximately in the first week of January, on a Saturday morning in the secured unit. R5 was heard yelling Stop, stop. CNA2 entered the room and witnessed R5 being forced to take the medications. CNA1 was holding R5's head, and LPN1 was holding R5's chin, and tried to put the medications in R5's mouth in a standing position. CNA2 intervened and told LPN1 could not force R5 and to try later. CNA2 explained the incident was reported to R5's family the same day, and the family responded it happened in the past. CNA2 indicated did not report the incident to the supervisor or abuse coordinator, but the family brought the matter to the management and the facility investigated the incident a few weeks later. The facility provided education during the investigation.</p> <p>On 05/16/2024 at 2:50 PM, CNA1 indicated sometime in the first week of January, CNA1 walked over to R5's room when R5 was heard yelling. CNA1 indicated LPN1 was in the room, forcing R5 to take the medications. CNA1 denied helping LPN1. CNA1 indicated did not report the incident to the abuse coordinator until after being interviewed after a month. CNA1 indicated was suspended, reinstated, and provided abuse training.</p> <p>The Director of Staff Development (DSD) indicated the staff were provided abuse training upon hire and every other month. The abuse incident should have been reported to the abuse coordinator immediately and reported within 24 hours to the state agency. The DSD confirmed the involved staff had completed their abuse trainings. The DSD indicated the resident who had a diagnosis of Alzheimer's had the right to refuse and should have been respected and not forced.</p> <p>On 05/16/2024 at 2:54 PM, the Director of Nursing (DON) confirmed there was a delay in the investigation and reporting because there was confusion in the early stages of the investigation. The DON indicated the incident was investigated and substantiated when LPN1 forced R5 to take the medications. The DON indicated LPN1 was suspended and resigned later, CNA1 was suspended but reinstated and provided education. The facility reported the incident to the nursing board.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 05/16/2024 in the afternoon, the former administrator recounted the incident was substantiated when it was validated LPN1 forced R5 to take the medications. The former administrator asserted forcing the resident to take the medications was unacceptable and considered it a form of abuse.</p> <p>The facility report to the board of nursing on 02/27/2024, documented on 01/31/2024, R5's family reported to the administrator an incident happened approximately four weeks ago, LPN1 forced R5 to take the medication with the help of CNA1. The validity of the claim CNA1 held R5's head could not be substantiated. LPN1 forced R5 to take the medications, as witnessed by CNAs. Per LPN1, there was no forcing of medications, and R5's family was always present during medication administration time. Forcing medications when a resident refused was considered abuse. The facility suspended and reinstated CNA1, while LPN1 resigned.</p> <p>The Abuse Prevention Test documented elderly people with dementia who frequently yell and resist care were most at risk for abuse. The suspicion of abuse should have been reported immediately to the supervisor.</p> <p>A facility policy titled Resident Rights revised 12/2016, documented employees should treat all residents with kindness, respect, and dignity.</p> <p>A facility policy titled Abuse Investigation and Reporting dated 07/2017, documented an alleged violation of abuse would be reported immediately but not later than 2 (two) hours if the alleged violation involved abuse.</p> <p>Complaint #NV00070507</p> <p>Facility Reported Incident #NV00070372</p>