

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 02/13/2025
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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51395</p> <p>Based on interview, record review and document review, the facility failed to ensure a resident was kept safe from physical abuse for 1 of 12 sampled residents (Resident 10). The deficient practice had the potential for the resident to experience emotional and physical harm.</p> <p>Findings include:</p> <p>Resident 10 (R10)</p> <p>R10 was admitted on [DATE] with diagnoses including acute respiratory failure with hypoxia, chronic obstructive pulmonary disease, and diabetes mellitus type 2.</p> <p>The facility reported incident (FRI) dated 12/23/2024 documented the following:</p> <p>-On 12/19/2024 at approximately 1:15 PM, R10 was in bed being cared for by two Certified Nurse Assistants (CNA), Employee 9 and 10 (E9 and E10).</p> <p>- Per E10 an exchange of inappropriate and abusive language occurred between E9 and R10. This verbal altercation escalated, leading to E9 striking R10 in the rib area with a closed fist.</p> <p>-Conclusion: The allegation of physical abuse by E9 against R10 was substantiated. The police department was contacted and responded to the incident. Subsequently E9 was taken into custody.</p> <p>A progress note dated 12/19/2024 documented R10 had a Head-to-toe assessment performed to check for bruising/wound progression. At that time no bruising or discoloration noted in patient chest & rib area. Patient has no complaints of pain or discomfort.</p> <p>A Social Service visit note dated 12/23/2024 documented the Social Services Director and Administrator visited R10 regarding the self-report. R10 was provided emotional support and offered Behavioral Health Services psych services, R10 denied the need for services. R10 reported no psychosocial harm from the incident and reported were not experiencing any emotional distress from the incident.</p> <p>A Care Plan dated 12/23/2024 documented R10 was involved in an altercation with a staff member. Interventions included the following:</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> -Provide a safe environment for R10. -Ensure employees are aware of policies and procedures for Abuse prevention and reporting. -Encourage R10 to verbalize concerns. -Monitor R10 for behaviors associated with the incident. -Notify MD of any changes. <p>On 02/13/2025 at 9:10 AM, R10 stated they share a room with their spouse. R10 stated had an incident with one CNA punching them in the left side of their ribs. The resident shared had started screaming and asked their spouse to get the Director of Nursing, another CNA was present in the room, and had stood there looking as if afraid. The staff intervened and handled the situation, and the CNA was arrested by the police. R10 verbalized were happy with how management handled the situation, and they feel safe in the facility.</p> <p>On 02/13/2025 at 1:15 PM the Director of Nursing (DON) confirmed E9 was immediately removed from R10's room and was suspended pending the investigation. The allegation of abuse was substantiated and was witnessed by another CNA resulting in termination and arrest of E9. The DON confirmed E9 was reported to the State Board of Nursing regarding the incident.</p> <p>During the onsite investigation on 02/13/2025, the facility's correction of the past non-compliance related to the incident occurred as evidenced by:</p> <ul style="list-style-type: none"> -Observation of staff and resident interactions were professional and courteous. -Interviews with residents revealed the residents were happy with staff and were treated in a polite manner. - CNA's and Licensed Nurses indicated the facility provided continuing education regarding Abuse and Neglect. -Review of the facility's employee file for E9 revealed reference and background checks were completed. -Review of the facility's training records corroborated the staff interviews regarding training. <p>Facility Reported Incident #NV00073005</p>		