STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295008	A. Building B. Wing	03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
El Jen Skilled Care	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)
F 0627 Level of Harm - Actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and document review, the facility failed to ensure:1) a resident was readmitted to the facility following hospitalization for 1 of 8 sampled residents (R1), and2) written criteria addressing residents hospitalized under a legal hold (L2K) was formulated and implemented. The deficient practice resulted in R1, who required medication management, assistance with activities of daily living, and nursing supervision, being left without housing, care, and access to prescribed medications, placing the resident at risk for serious harm, including deterioration in condition, hospitalization, or death.The deficient practice had the potential to affect other residents in the facility who required similar services if the practice continued.Findings include:Resident 1 (R1) was admitted on [DATE], with diagnoses including diabetes mellitus, long-term insulin use, chronic ulcer of right lower leg, cellulitis, infective myositis, muscle weakness, difficulty in walking, reduced mobility, pulmonary embolism, hypertension, chronic pain and anxiety disorder.R1's Quarterly Minimum Data Set, dated [DATE], documented a brief interview of mental status (BIMS) score of 15/15, indicating R1's cognition was intact.Nursing progress notes dated 02/03/2026, documented R1 was involved in a resident-to-resident altercation in the designated smoking area with two other residents. R1 was verbally aggressive toward one resident and threw a red ashtray at another resident. The physician was notified and ordered R1 to be placed on a L2K for further evaluation. R1 was sent to the hospital under a L2K. R1 left the facility via gurney with transportation at 9:30 PM.A physician order dated 02/03/2026, documented transfer of R1 to the hospital under L2K.Hospital records dated 02/03/2026 documented that R1's behavioral symptoms stabilized while in the emergency department and were assessed as secondary to psychiatric illness. R1 was medically cleared and deemed appropriate for further psychiatric evaluation. The records indicated R1 remained a danger to self and unable to care for self, with repeated evaluations showing ongoing psychotic behavior without significant improvement. The hospital disposition documented R1's discharge with a final diagnosis of acute situational disturbance. On 03/19/2026 at 11:30 AM, a Physician Assistant indicated a resident may be placed on a legal hold or L2K when a danger to self or others. The Physician Assistant indicated a resident discharged under an L2K could be readmitted to the facility on ce hospital discharge clearance or disposition was obtained.On 03/19/2026 at 11:43 AM, a Registered Nurse (RN) familiar with R1 during day shift, confirmed R1 was transferred to the hospital under an L2K, returned to the facility the next day, and was denied readmission. The RN indicated an L2K was initiated when a resident was considered a danger to others, including behaviors such as physical aggression, threats, or uncontrolled behavior. The RN indicated the physician determined whether to proceed with an L2K. The RN indicated a resident transferred to the hospital was considered discharged from the facility once admitted . The RN indicated if a resident returned within 24 hours, the determination of discharge or readmission depended on the administrator and the situation. On 03/19/2026 at 12:30 PM, the Director of Nursing (DON) explained the basis for an L2K was when a resident was a danger to self or other residents, and the physician provided the order with RN sign-off. The DON indicated R1 was placed on an L2K following a three-person altercation, (continued on next page)

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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F 0627 Level of Harm - Actual harm Residents Affected - Few	during which R1 pushed another resident and attempted to throw an ashtray multiple times, and was very aggressive and posed a danger to others. The DON indicated that a resident returning from the hospital required readmission clearance and verbal report prior to return. R1 arrived at the facility without notification, documentation, or confirmation of discharge and arrived at the facility. Staff did not attempt to contact the hospital because R1 refused and did not want to go back to the hospital. R1 was very upset and law enforcement was contacted and the resident was trespassed.The DON explained when residents were sent to the hospital, staff packed and completed an inventory of their belongings, as rooms could be reassigned. The DON verbalized a bed hold was available for a fee; however, residents under an L2K were not typically offered a bed hold. The DON was unsure if it was offered in this case. The DON explained medications were not provided as R1 was not readmitted and no physician order was available. On 03/19/2026 in the afternoon, during a telephone interview R1 indicated not being admitted to the hospital due to no criteria for the psychiatric hold. R1 was treated in the emergency department prior to discharge. The hospital arranged transportation back to the facility and upon arrival, R1 was told readmission would not occur, and their previous room was occupied by another resident. The facility staff refused to accept R1's hospital discharge papers. R1 indicated facility staff were aware they had no home, no family in the area, and no resources. R1 indicated law enforcement was contacted by the facility, and they were trespassed from the property. R1 verbalized staying at a bus stop near the facility for several days following the refusal of readmission. R1 indicated, During that time, I was hungry, had no money, was cold, and had no medications, which resulted in hospitalization.On 03/19/2026 at 1:25 PM, a case manager (CM) indicated the facility was aware R1 had no home and no resources. The CM explained that R1 received custodial care while in the facility and applied for Medicaid after their insurance lapsed in January. The CM indicated the discharge plan was for R1 to obtain a weekly apartment or shared housing; however, was waiting for financial resources. The CM explained not being responsible for ensuring placement or discharge needs when R1 was not readmitted . The CM explained R1's belongings were packed once discharged , which occurred when the resident was admitted to the hospital. R1's room was reassigned to another resident.On 03/19/2026 at 4:27 PM, a receptionist indicated the facility received multiple calls from the hospital prior to R1's arrival regarding the transfer. The receptionist indicated the calls were transferred to case management, then the receptionist was informed the facility would not readmit R1. The receptionist confirmed the hospital called three times, and denial of readmission was confirmed by case management and the marketing director.The receptionist indicated R1 arrived at the facility via hospital transportation with two Emergency Medical Technicians, and R1 was in a wheelchair. The receptionist indicated R1 was positioned near the nurse's station and requested to return to the previous room. Nursing staff informed R1that readmission would not occur, their belongings had been packed, and another resident had been assigned to the room.The receptionist indicated R1 became verbally aggressive after being informed readmission would not occur and their previous room was occupied by another resident. The receptionist indicated Metro Police were contacted, issued a trespass notice, and escorted R1 off the property.On 03/20/2026 at 10:44 AM, during a telephone interview, an attending physician confirmed R1 was transferred to the hospital under a L2K following an altercation involving multiple residents. The physician indicated readmission decisions were determined by the administrator. The physician indicated R1 required assistance and was unable to safely care for self independently. The physician conveyed discharge without appropriate placement and access to medications placed R1 at risk for serious harm, including unmet medical needs, rapid deterioration in condition, hospitalization, or death. On 03/20/2026 in the afternoon, the marketing director indicated R1 was sent to the hospital under a L2K following an altercation involving other residents. The marketing director indicated facility's policy was to deny readmission for residents sent out under an L2K and indicated residents out of the facility for more than 24 hours were considered discharged from the system.The marketing director indicated the decision not to readmit R1 was made prior to R1's return and was based on (continued on next page)

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F 0627 Level of Harm - Actual harm Residents Affected - Few	direction from the administrator. The marketing director indicated once advised not to accept R1 back, the bed was filled and was no longer available for R1 upon return. The marketing director indicated exceptions to this practice occurred and confirmed another resident involved in a similar incident was readmitted due to long-term residency status.On 03/20/2026 at 1:00 PM, the Director of Nursing (DON) indicated the facility was licensed for 144 beds, with 133 occupied on 02/04/2026, confirming space was available. The DON confirmed there was noˆpolicy governing L2K or hospital readmissions and described existing procedures as vague. Staff followed verbal direction from leadership. The DON indicated the administrator was on leave and unavailable for interview.Hospital records dated 02/11/2026, documented R1 presented with worsening leg swelling. The records indicated R1 had a history of deep vein thrombosis (DVT) and pulmonary embolism. The records indicated R1 resided in a long-term-care facility and was not accepted for readmission. The records revealed R1 was not receiving prescribed medications and experienced worsening leg swelling, which prompted R1 to seek medical care. Ultrasound confirmed a positive DVT. The facility policy titled Transfer and Discharge, dated 04/11/2025, documented residents transferred to an acute care setting were permitted to return to the facility upon discharge.The facility policy titled Behavioral Health Services, revised 03/20/2026, was updated following identification of the deficient practice. The policy revision included processes for psychiatric holds, resident return rights, and readmission upon medical or psychiatric clearance. The policy documented support for appropriate use of psychiatric holds in accordance with applicable laws and regulations, that residents transferred under psychiatric hold retained resident rights, including the right to return to the facility, and that residents were readmitted upon medical or psychiatric clearance from the receiving provider or hospital.