| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 295008 | A. Building<br>B. Wing | 05/26/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| El Jen Skilled Care | 5538 W Duncan Dr<br>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 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and document review the facility failed to ensure a comprehensive care plan was completed for 1 of 6 sampled residents (Resident 1). The deficient practice had the potential for a resident not to have a person-centered intervention to assist with health care needs.Findings include:Resident 1 (R1) was admitted on [DATE], with diagnoses including schizophrenia and bipolar disorder. An Initial Psychiatric Evaluation dated 04/30/2026, documented the resident has not exhibited any physical or verbal aggressive behaviors but does exhibit inappropriate behaviors needing redirection, per staff: Resident was sarcastic in nature. A Behavior/Psych Change of Condition dated 05/06/2026 documented, R1 exhibited inappropriate behaviors, including making sexual comments toward a nurse, including asking the nurse to sit on their lap. The note included redirecting the resident remaining calm and boundaries reinforced. R1 also grabbed this nurse's hair clip and clipped hair clip to hairy nipple area. When attempted to redirect resident behavior, R1 stated just clean the hair clip. A Social Service Note dated 05/11/2026 documented R1 was followed by Social Services regarding allegations of sexually inappropriate behavior toward staff. R1denied allegations of exposing his private areas to female kitchen staff. Social Services discussed the importance of maintaining appropriate boundaries and respectful behavior toward all staff members. R1 verbalized understanding and agreed to refrain from disturbing kitchen staff or making any inappropriate gestures, comments, or behaviors toward staff moving forward. Facility staff will continue to monitor and report any further concerns. Talk therapy offered, resident declined. Behavior/Psych Change of Condition dated 05/06/2026 documented R1 approached the nursing station requested medication and upon looking at resident, their genitals were out. This nurse quietly told resident that they were exposed, and the resident responded, No I'm not, I have a brief on see and grabbed self. The nurse you informed the resident they needed to cover up to which R1 responded no. The nurse reported the incident to the reported to ADON. A Psychiatry Follow Up visit was completed on 05/14/2026 including a plan and recommendations to monitor hours of hours of sleep, practice sleep hygiene, and to monitor inappropriate sexual behaviors. R1's medical record lacked documented evidence the Psychiatrist's recommendation to monitor target behavior for inappropriate sexual behavior. The documented behavioral incidences did not trigger the facility to create a care plan to address the behavior. A Social Service Note dated 05/18/2026 documented Social Services was notified of an alleged sexual abuse incident involving the resident with another resident that had reportedly occurred this morning. R1's care plan was updated on 05/18/2026 to include a care plan for inappropriate sexual behavior. On 05/26/2026 at 2:05 PM, the assistant director of nursing (ADON) indicated all nursing staff were responsible for creating a resident's care plan. Change in behavior, inappropriate behavior and recommendations should have cued the staff in creating a care plan. On 05/26/2026 at 2:35 PM, the director of nursing (DON) reviewed the medical record and agreed a care plan should have been created to address the inappropriate behavior. The DON indicated creation of a care plan ensures interventions were put into place to address the resident's needs. The facility policy titled Comprehensive Care Plan (undated), documented it is the policy of this facility to develop<br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 295008 | A. Building<br>B. Wing | 05/26/2026 |

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| El Jen Skilled Care | 5538 W Duncan Dr<br>Las Vegas, NV 89130 |

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|---|---|
| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | and implement a comprehensive person-centered care plan for each resident, consistent to meet a resident's medical, nursing and mental and psychological needs and all services that are identified.<br>FRI 3017458 |

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|---|---|
| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident?s drug regimen must be free from unnecessary drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and document review, the facility failed to ensure common side effects monitoring for psychotropic medications were initiated for 1 of 6 sampled residents (Resident 1). The deficient practice had the potential for a resident not to be monitored for serious adverse reactions of medication preventing the prompt implementation of interventions.Findings include:Resident 1 (R1) was admitted on [DATE], with diagnoses including schizophrenia and bipolar disorder. A physician order dated 04/16/2026, documented Quetiapine Fumarate (Seroquel) 200 milligrams (mg)two times a day for schizophrenia. The prescription was flagged with a black box warning (warnings are mandated only when clinical data shows a drug carries a significant risk of severe adverse events). The medication Seroquel (quetiapine) carried a warning (the most serious safety alerts): an increased risk of death in elderly patients with dementia-related psychosis and a higher risk of suicidal thoughts and behaviors in children, teens, and young adults A physician order dated 04/30/2026, documented Trazodone HCL 100 mg give 1 tablet by mouth one time a day for sleep. The prescription was flagged with a black box warning. The warning on trazodone suggests the increased risk of suicidal thoughts and behaviors in children, teenagers, and young adults (under [AGE] years old). R1's medical record lacked documented evidence of side effect monitoring for the specified medications. The medication administration record (MAR) or the comprehensive care plan lacked documentation of the side effect monitoring. On 05/26/2026 at 2:05 PM, the assistant director of nursing (ADON) indicated residents receiving psychotropic medications should have had side effect monitoring completed on the MAR. The nurse entering the psychotropic medication on the physician order should have entered side effect monitoring orders in the MAR as well. On 05/26/2026 at 2:35 PM, the director of nursing (DON) reviewed the medical record and agreed there was no side effect monitoring was completed for the two psychotropic medications prescribed to R1. The DON confirmed side effect monitoring should have been completed on the MAR. The facility policy titled Use of Psychotropic Medication(s) dated 04/28/2026, documented the resident's response to the medication, including progress towards goals and presence/absence of adverse consequences, shall be documented in the resident's medical record. FRI 3017458 |