STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295008	A. BUILDING _____ B. WING _____	05/20/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
EL JEN CONVALESCENT HOSPITAL AND RETIREMENT CENTER	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 0604 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review and document review, the facility failed to implement restraint interventions consistent with facility policies and manufacturer instructions for 5 of 11 residents by ordering a restraint on an ambulatory resident who had eloped from the facility for staff convenience (Resident #1), failing to ensure a resident was wearing the correct, physician-ordered restraint device (Resident #2) and failing to conduct pre-restraining evaluations for residents utilizing restraints (Residents #1, #2, #4, #10 and #11). Findings include: Resident #1(R1) was admitted on [DATE] with [DIAGNOSES REDACTED]. On 05/12/2020 at 4:57 PM, R1 eloped from the facility for over an hour before being located and returned by facility staff. On 05/13/2020 at 12:31 PM, a pre-restraining evaluation showed the resident was able to sit upright, turn independently in bed, and transfer in and out of bed independently. A self-release belt was recommended to be used only when staff were caring for other residents and could not provide one on one. R1's ambulation status was not documented. The evaluation was not completed, saved, and signed by the evaluator. A Physician order [REDACTED]. On 05/15/2020 at 12:55 PM, the Licensed Practical Nurse indicated R1 was ambulatory and did not use a wheelchair. A Certified Nurse Assistant indicated R1 was ambulatory and did not use a wheelchair. On 05/15/2020 at 3:56 PM, the Director of Nursing acknowledged the soft belt restraint intervention was questionable for a resident who did not use a wheelchair, and the pre-restraining evaluation should have been completed. Resident #2 (R2) was admitted on [DATE], with [DIAGNOSES REDACTED]. A Physician Ordered dated 01/22/2020 at 4:57 PM, documented a self-releasing soft belt when up in the wheelchair for safety. A Physician Ordered dated 01/28/2020 at 11:00 PM, documented a self-releasing soft belt when up in the wheelchair for unsteady gait and frequent falls. On 05/15/2020 at 1:10 PM, R2 was observed in the unit hallway sitting in a wheelchair with a soft belt restraint. A couple of attempts were made to ask the resident to release the restraint, including in Spanish, R2's native language. The resident did not respond. On 05/15/2020 at 2:00 PM, R2 was observed in the unit hallway sitting in a wheelchair with a soft belt restraint. On 05/15/2020 at 2:16 PM, a Restorative Aide acknowledged R2 had a self-release belt ordered. On 05/15/2020 at 2:30 PM, the Restorative Aide had confirmed a soft belt restraint, not a self-releasing belt. On 05/15/2020 at 3:42 PM, the Resident Care Coordinator (RCC) confirmed R2 had a self-releasing belt ordered but wore a soft belt restraint. On 05/15/2020 at 3:56 PM, the Director of Nursing (DON) acknowledged the facility lacked documented evidence of a pre-restraining evaluation. Documentation showed a blank pre-restraining evaluation at 3:20 PM on 01/31/2020. The DON acknowledged the restraints were re-evaluated quarterly, R2's clinical record lacked documented evidence the restraint was evaluated quarterly. Resident #4 (R4) was admitted on [DATE], with [DIAGNOSES REDACTED]. A Physician order [REDACTED]. On 05/19/2020 in the morning, the Medical Records Supervisor acknowledged R4's clinical record showed the last pre-restraining evaluation was dated 04/06/2019, showing no quarterly re-evaluations since. Resident #10 (R10) was admitted on [DATE], with [DIAGNOSES REDACTED]. A Physician order [REDACTED]. On 05/19/2020 in the morning, the Medical Records Supervisor acknowledged R10's pre-restraining evaluation dated 07/28/2014 was from a previous admission. R10's clinical record lacked documented evidence of a pre-restraining evaluation coinciding with the admission date of [DATE] or quarterly re-evaluations. On 05/19/2020 - 05/20/2020, there were multiple observations of R10 wearing a vest restraint. On 05/19/2020, in the late afternoon, the Director of Nursing indicated R10's vest restraint was attached to the wheelchair, which was obtained by special order via social services. On 05/20/2020 in the morning, a Licensed Practical Nurse acknowledged the vest attached to R10's wheelchair was a restraint. R10's clinical record lacked documented evidence of a physician's orders [REDACTED]. Resident #11(R11) was admitted on [DATE], with [DIAGNOSES REDACTED]. A Physician order [REDACTED]. On 05/19/2020 in the morning, the Medical Records Supervisor acknowledged R11's clinical record showed two pre-restraining evaluations dated 08/28/2019 and 02/14/2020, demonstrating pre-restraining evaluations were not completed quarterly. On 05/19/2020 at 1:39 PM, a Licensed Practical Nurse acknowledged R11 continued to use a soft belt restraint. On 05/20/2020 in the late afternoon, the Assistant Administrator acknowledged the aforementioned issues with R1, R2, R4, R10, and R11. The facility's Use of Restraints policy (undated) Section #6, revealed prior to placing a resident in restraints, there should be a pre-restraining assessment and review to determine the need for restraints. The assessment should determine the possible underlying causes of the problematic medical symptom and determine if there were less restrictive interventions that might improve symptoms. The facility's Level III Physical Restraint Application policy (undated), Preparation #1, revealed: verify physician's orders [REDACTED]. Under the Before Applying Any Restraint section: Make a complete assessment of the patient to ensure restraint use is appropriate. Identify the patient's symptoms and, if possible, remove the cause. You may need to: cater to individual needs and routines; increase rehabilitation and restorative nursing; modify the environment, or increase supervision. Use a restraint when all other options have failed. The facility's Posey Self-Releasing Padded Belts Application Instructions dated 2009, under the Contraindications section, revealed: Do not use on a patient who is unwilling or unable to follow instructions, and is at risk of a fall or re-injury from self-release.
F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, clinical record review, and document review, the facility failed to ensure adequate supervision and 15-minute safety checks were implemented to prevent an elopement for 1 of 11 sampled residents (Resident #1). Findings include: Resident #1 (R1) was admitted on [DATE], with a primary [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. R1's care plan dated 01/22/2020, documented R1 would be monitored by staff to ensure the resident did not leave the facility unattended and to monitor the resident's location every 15 minutes while awake. A review of R1's clinical record revealed 15-minute safety checks were not completed from 02/19/2020 to 05/19/2020. A behavior chart used for behavior monitoring dated 05/12/2020 documented R1 escaped from the facility at 5:00 PM, and a search was conducted. R1 was found trying to enter an apartment complex located next to a major intersection at 6:30 PM. A Progress Note dated 05/12/2020, documented at approximately 6:00 PM, a Certified Nursing Assistant (CNA) alerted, a Licensed Practical Nurse (LPN) R1 was missing. The LPN instructed all CNAs on the unit to check residents' rooms, bathrooms, common areas, and utility rooms. R1 was not found in those areas. A facility report dated 05/12/2020, documented at approximately 6:00 PM a CNA alerted the LPN, R1 was missing. The Resident Care Coordinator (RCC) was notified and contacted 911. At 6:30 PM, R1 was found by staff unharmed walking into a nearby apartment complex, and the 911 call was canceled. On 05/15/2020 at 12:27 PM, the LPN who was working on the unit at the time of R1's elopement revealed she was charting at the nurse station located

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

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.

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) approximately 14 feet (ft) from the door R1 used to elope. The LPN indicated a CNA redirected a different resident away from the door at the time of the incident. The LPN was first notified R1 was missing on 05/12/2020 at approximately 6:00 PM. The LPN indicated R1 had eloped at approximately 5:00 PM. The LPN confirmed R1's location was not monitored every 15 minutes, per the physician's orders [REDACTED]. On 05/19/2020 at 3:55 PM, a CNA who was caring for R1 at the time of the incident indicated R1 had eloped from the facility at approximately 5:00 PM on 05/12/2020 and notified the LPN, R1 was missing at 6:00 PM on 05/12/2020. The CNA confirmed 15-minute checks to monitor R1's location were not completed on 05/12/2020. On 05/15/2020 at 1:58 PM, the RCC indicated video footage of the incident revealed a CNA and an LPN were sitting at the nurse's station charting at the time of the incident. The RCC explained a different resident was observed pushing on the secured unit door until it eventually opened. The RCC indicated when pushed consecutively for 15 seconds, the door would open, and an alarm would sound. The RCC verbalized once the door opened, R1 eloped through the door. The RCC explained after R1 eloped, the CNA looked up and intervened by redirecting the resident who was observed pushing on the door, and ensured the door was secured. The RCC verbalized the CNA should have walked the hallways outside of the secured unit to ensure no residents had eloped unobserved. The RCC confirmed the video footage documented R1 eloped through the door on 05/12/2020 at 4:57 PM. On 05/15/2020 at 3:56 PM, the Director of Nursing (DON) indicated 15-minute safety checks to monitor R1's location were not completed from 02/19/2020 to 05/15/2020. The DON explained the 15-minute safety checks should have been completed. The DON indicated a physician's orders [REDACTED]. On 05/19/2020 at 10:06 AM, one-to-one supervision for R1 was not observed. R1's clinical record lacked documented evidence a physician's orders [REDACTED]. On 05/19/2020 at 10:11 AM, an LPN confirmed 15-minute safety checks for R1 had not been completed from 05/12/2020 to 05/19/2020. The LPN was unaware of any new interventions put into place since R1 eloped on 05/12/2020. On 05/19/2020 at 3:57 PM, a CNA who provided care for R1 on 05/17/2020 revealed R1 had not received one-to-one supervision. The Medical Records Supervisor acknowledged the clinical record lacked documented evidence 15-minute checks were completed from 02/19/2020 through 05/18/2020. R1's care plan lacked documented evidence a new intervention for R1's elopement risk to include one on one supervision was developed. The facility's policy titled 15-minute Checks revised on 05/19/2020, documented CNAs would document the 15-minute check activity every 15 minutes. The facility's policy titled Elopement/Wandering/Exit Seeking, Unsafe Resident revised on 05/19/2020, documented residents who were an elopement/wandering/exit seeking would be on 15-minute checks unless other orders were written. The nurse who received the order for 15-minute checks would be responsible for entering the order on the treatment sheet, filling out a 15-minute log, give to assigned CNA, and place a green band on the resident. On 05/19/2020 in the afternoon, R1's clinical record was reviewed with the Medical Records Supervisor for previous documentation regarding the 15-minute checks ordered on [DATE]. The current physician order [REDACTED]. The overflow chart review revealed a pattern of failing to document the 15-minute checks. The Medical Records Supervisor acknowledged the clinical record lacked documented evidence 15-minute checks were completed from 02/19/2020 through 05/18/2020. R1's care plan lacked documented evidence new interventions for R1's elopement risk tendencies. Facility Reported Incident #NV 059