STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002745	A. BUILDING: _____ B. WING _____	C 05/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EL PASO HEALTH CARE CENTER	850 EAST SECOND STREET EL PASO, IL 61738

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Facility Reported Incident of 4/11/21, 5/15/21 & 5/18/21/IL134180 F600 cited Facility Reported Incident of 5/16/21/IL134176 F-689 cited	S 000		
S9999	Final Observations 1) Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b) 300.1210c)3) 300.1210d)6) 300.1220b)2)3) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.	S9999		

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S9999	Continued From page 2 d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a	S9999		

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S9999	Continued From page 3 resident. (Section 2-107 of the Act) These Regulations were not met as evidenced by: Based on observation, interview and record review, the facility failed to protect one resident from physical abuse by other residents, failed to supervise while wandering in resident Common areas, failed to supervise while wandering in and out of other resident rooms and during group smoking times for one resident (R1) reviewed for abuse. This failure to supervise R1 while among other residents continues to leave R1 at risk for potential of abuse. Findings include: Facility Abuse policy dated 4/2021, documents "As part of the resident social history assessment, staff will identify residents with increased vulnerability for abuse or who have needs and behaviors that might lead to conflict. Through the care planning process, staff will identify any problems, goals, and approaches, which would reduce the chances of mistreatment, neglect, and abuse of these residents. Staff will continue to monitor the goals and approaches on a regular basis. Facility reported incident dated 2/25/21 documents "On 2/21/21 an allegation of physical altercation involving (R1) and (R9) was reported. (R9) stated " I asked (R1) to go to her room because (R1) was bugging me and then I pushed her. I said I was sorry afterward." Upon completion of the investigation, the facility believes that the incident did occur secondary to (R1) resident diagnosis."	S9999		

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S9999	Continued From page 4 Facility reported incident dated 4/16/21, documents "On 4/11/21, an allegation of physical altercation involving (R4) and (R1) was reported. (R6) stated "I saw (R4) hit (R1) in the arm. (R4) stated (R1) is always in the way, so (R4) hit (R1)." Upon completion of the investigation, the facility believes the incident did occur due to (R4) becoming upset with (R1) sitting in her chair and also secondary to resident diagnosis." Facility reported incident dated 5/21/21, documents "On 5/15/21, an allegation of physical altercation between (R1) and (R2). (R2) stated "I was in the doorway to get out to the courtyard for smoke pass. She (R1) was behind me while I was sitting in my wheelchair in the doorway trying to push me. She kept trying to push me out the door when I told her to stop. (R1) was continuing to push me, so I backhanded her." (V8) Activity Aide, "I did witness the altercation. (R1) was trying to push (R2) outside the door to the courtyard. Then (R2) got upset with (R1) and backhanded her in the face." Upon conclusion of the investigation, the facility believes the incident did occur secondary to resident diagnosis. Activities will modify the smoking schedule so that (R2) and (R1) have different smoking times." Facility reported Incident dated 5/25/21, documents "On 5/18/21, an allegation of physical altercation between (R1) and (R3). (V7) Activity Aide, stated "I was conducting smoke pass and (R3) was wheeling himself out to the courtyard. (R1) was behind him and started to push him in his wheelchair. (R3) didn't like that so he backhanded her, and I separated the two residents." Upon completion of the investigation, the facility believes the incident did occur secondary to resident diagnosis. Activities will modify the smoking schedule so that (R3) and	S9999		

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S9999	Continued From page 5 (R1) have different smoking times." R1's medical record documents R1 has a diagnosis of major depressive disorder, psychosis, anxiety, post-traumatic stress disorder (PTSD), acute-enchephalopothy with memory loss and insomnia. Brief interview of mental status (BIMS) is undetermined due to communication deficit. On 5/26/21 at 9:03 AM, V6, Licensed Practical Nurse/Resident Care Coordinator (RCC), stated "Over the last few months, (R1)'s behavior has gotten worse. We have a referral to a neurologist in because (R1) went from being able to communicate, to now not being able to really communicate. We did change (R1)'s smoking schedule to minimize her interactions with the other residents." On 5/26/21 at 8:53 AM, V2, Certified Nursing Assistant (CNA), stated "I don't think there's anything in writing, but we were told to keep a close eye on her and redirect her when she goes into other resident rooms or when she was invading other resident's personal space." On 5/26/21 at 8:56 AM, V5, CNA, stated "There isn't anything written in our communications sheets about (R1), but I know to keep a close eye on her and redirect her when she goes into other resident rooms or when she gets around groups of other residents." On 5/25/21, R1 observed throughout the day wandering around the facility. R1 observed walking into another resident's room, staff offices and standing with other residents congregated together. Staff did not redirect R1 out of resident's room or away from the residents that were	S9999		

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S9999	Continued From page 6 grouped together. R1's medical record does not contain a referral for a neurologist consult. R1's current care plan does not address R1's recent change in behavior or resident to resident altercations with intervention for the facility reported incidents of 2/21/21, 4/11/21, 5/15/21, and 5/18/21. R1's behavior tracking dated February 2021 and April 2021 do not document behaviors. R1's behavior tracking dated May 2021 does not document behaviors on 5/15/21 and 5/18/21. On 5/26/21 at 11:55 AM, V3, Minimum Data Set/Care Plan Coordinator (MDS/CPC), verified the information for R1's recent change in behavior and resident to resident altercations should be in the care plan, but has not been entered. V3, MDS/CPC also stated "I'll be honest with you, we had a mass exodus last month and a lot of things aren't getting done that should. I'll try and find the behavior tracking for (R1), but since we don't have Social Services right now, I'm not sure what's being done and what's not. I'm not the full time MDS/CPC coordinator. I'm at this facility more than others, but that's a couple days a week." On 5/27/21 at 2:00 PM, V10, Medical Director, stated "I didn't put in a neurological consult for (R1) because I wasn't aware that she needed one." (B)	S9999		

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S9999	Continued From page 7 2) Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c)3) 300.1210d)6) 300.1220b)2)3) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:	S9999		

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S9999	Continued From page 8 c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.	S9999		

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S9999	Continued From page 9 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, These Regulations were not met as evidenced by: Based on observation, interview and record review, the facility failed to evaluate and identify the risk associated with the use of a motorized wheelchair for one (R8) resident reviewed for accidents. This failure resulted in R8 running her motorized wheelchair into stationary objects causing significant injury as evidence by R8 sustaining fractures to the first metatarsal base and the second through fourth metatarsal necks of the left foot and dislocation of the 1st-3rd metatarsals of the right foot. Findings include: Facility Motorized Wheelchair policy, undated, documents "Each resident will be evaluated for the need and safe use of motorized wheelchairs. Conduct an Illinois Department of Healthcare and Family Services (HFS) evaluation for each new admission within 30 days of admission and then quarterly." R8's medical record documents R8 has a diagnosis of Schizophrenia, depression, anxiety and Parkinson's disease with a Brief Interview for Mental Status (BIMS) of 13. R8's medical record dated 2/17/21 documents "(R8) sustained a fracture to the first metatarsal	S9999		

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S9999	Continued From page 10 base and second through fourth metatarsal neck of the left foot. (R8) obtained the fractures as a result of running into a tote box in her closet with her motorized wheelchair." R8's hospital record dated 2/25/21 documents "(R8) was driving her mechanical wheelchair, and sustained a left foot injury. Per (R8), this has happened multiple times. Pain 9/10. X-ray that was done today shows displaced first metatarsal fracture. There is minimally displaced second through fourth metatarsal fractures." R8's medical record nurse's notes dated 3/31/21 documents "Resident complaining of foot pain. Stated she ran her wheelchair into her dresser earlier in the day. Her right foot is swollen and bruised down the medial side of the foot. X-ray results of right foot shows acute fractures of the first through fifth toes on right foot. X-ray results faxed to V10, Medical Director." R8's medical record dated 5/7/21 documents "(R8) sustained dislocation of the first through third metatarsal of the right foot. (R8) obtained the fractures as a result of bumping into an object while operating the motorized wheelchair. (R8) will be reassessed for appropriateness of motorized wheelchair." R8's hospital records dated 5/6/21 documents "(R8) noted some pain in her right foot. She states that it feels broken, similar to the previous fracture. X-ray obtained of right foot shows possible Lisfranc dislocation and malalignment of the third metatarsal with chronic base of the third metatarsals, subacute in nature with fourth metatarsal neck fractures with medial displacement along with a clinic healing first base of the first metatarsal fracture with second	S9999		

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S9999	Continued From page 11 through fourth metatarsal neck fracture with increased callus formation with partial progression of healing." R8's hospital record dated 5/7/21 documents "(V1, Administrator) calling regarding (R8) and recent X-ray findings. (R8) seen in office yesterday for follow up of left foot, but x-ray completed on right foot. (V1, Administrator) is asking if the results showed pre-existing issue or if it was as new finding. On the right foot, advised that report doesn't indicate this to be a pre-existing finding." On 5/25/21 at 11:33 am, R8 sitting in her wheelchair in front of her dresser. R8 pushed the control lever of the motorized wheelchair forward into the dresser where a cracking noise was heard. Resident stated she was trying to back up, but went forward instead. R8's room has two large holes in the wall about a foot off the ground, several scrapes along the walls and doors and a large piece of the wall missing from the corner. On 5/25/21 at 12:27 PM, V2, Certified Nursing Assistant (CNA), stated "We've told them we didn't think it was safe for (R8) to be in her wheelchair. She runs into things all the time. It's been ongoing ever since she got the wheelchair. You can see what she's been doing to her room. She runs into her bed all the time. We're concerned for her safety. You can see the bathroom door as well."The bathroom door frame is broken at the bottom where the door hinge attaches and is no longer secured to the frame. The door hinge at the top of the frame has a missing screw and the remaining screws are partially pulled out. As V2, CNA, opened the door, the door was not steady and had to be held with two hands to open.	S9999		

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S9999	Continued From page 12 On 5/25/21 at 12:33 PM, V11, Maintenance, verified the door was not in safe operating condition and stated "I'll have to get some longer screws to go through the broken frame and reattach the door for now. That should hold it in place." R8's Motorized Wheelchair Assessment documents R8 was assessed for use of a motorized wheelchair on 4/7/20, 6/17/20, 7/15/20 and 10/5/20. R8's current care plan does not address resident's motorized wheelchair or incidents of injury from motorized wheelchair. R8's Physical Therapy Plan of Care dated 7/10/20, documents R8 as using a manual wheelchair at time of assessment. R8's Physical Therapy Plan of Care dated 5/24/21 documents R8 as using a motorized wheelchair at the time of assessment and documents "(R8) exhibits decreased safety awareness for wheelchair mobility." On 5/25/21 at 2:12 PM, V3, Care Plan Coordinator (CPC) verified a motorized wheelchair assessment had not been completed since October 2020 and there was nothing in R8's care plan to address the motorized wheelchair. V3,CPC stated "The motorized wheelchair assessments should be completed initially and then every three months or quarterly. We also should have completed another motorized wheel chair assessment back February when (R8) broke her toes using it. I just got notification today that she did it again on 5/7/21. That's why I'll be completing one today."	S9999		

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S9999	Continued From page 13 On 5/25/21 at 3:00 PM, V1, Administrator, stated "(R8) was re-assessed today for the use of a motorized wheelchair and is no longer in one due to safety concerns." (B)	S9999		