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 09/19/2022

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 Complaint 2227312/IL151148	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 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	S9999	**Attachment A** Statement of Licensure Violations	

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S9999	Continued From page 1 resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: 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 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a 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 ensure appropriate interventions were implemented for a resident assessed as high risk for wandering, provide supervision when a daily wandering, cognitively impaired resident exited the building and failed to recognize the incident of elopement as an elopement for one resident (R7), reviewed for elopement risk. Findings include: These failures resulted in R7 not being	S9999		

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S9999	Continued From page 2 adequately supervised and exiting from the facility on 9/10/22 at 2:30am. The facility's Elopement Prevention policy, revised 10/06, documents that the IDT (Interdisciplinary Team) will imitate a plan of care for any resident determined high risk for elopement. Facility specific measures as well as resident specific measures will be included in each high risk resident's plan of care to minimize risk factors. Interventions of personal door alarm devices and monitoring will be initiated as deemed necessary by IDT and documented in the individual resident's plan of care. This form documents that the plan of care for minimizing elopement risks will be reviewed each time the Risk Assessment is completed with initials and dating of the care plan by any member of the IDT present for review. The facility's Resident Monitoring policy, revised 12/22/2017, documents to initiate monitoring of residents as nursing measure upon the clinical decision of the Charge Nurse and/or Interdisciplinary Team to assist in providing safety to residents that are identified to be a potential threat to self or others or an elopement risk. Document all assessments, needs, interventions and resident responses in the resident's medical record. R7's Cumulative Diagnosis Log documents a closed fracture of the lateral wall of the right orbit, maxillary sinus fracture, open, seizures, trauma, sarcoidosis, bipolar disorder, suicidal ideation/attempts, anxiety, depression, falls, gastroesophageal reflux disease, anemia. R7's Elopement Risk Assessment, dated 8/12/22, documents a score of 5, indicating that R7 is a	S9999		

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S9999	Continued From page 3	S9999		

high risk for elopement. R7's care plan documents that R7 has attempted to elope from the building and is currently on one on one supervision related to her behaviors. R7's Progress notes, dated 8/13/22, documents that R7 is exit seeking and running out different doors in the facility throughout the day. R7's medical record has no documentation concerning the incident that happened on 9/10/22.

On 9/13/22 at 9:00am, R7 was in the courtyard with V8, Unit Aide. R7 stated that she left the building because she does not want to be here. R7 stated that she was going to buy a pack of cigarettes. R7 asked several times "What time is smoke time" over a period of 10 minutes. V8 verified that R7 wanders and attempts to leave the building. V8 stated that R7 has been one on one since she was admitted to the facility. On 9/14/22 at 5:25am, R7 was in her room unattended by staff. There were no staff located in the area of R7's hall.

On 9/14/22 at 5:30am, V10, CNA, Certified Nursing Assistant, stated that on 9/10/22, R7 was sitting in the hall outside of her room, then would walk to the nurses station and back to room. V10 stated that when her and V9 started rounds, R7 took off out the front door. V10 stated that there were only three staff that night, V10, V9, CNA's and V11 Registered Nurse, so there is no way one on one supervision can be done. V10 verified that R7 is on one on one supervision since admission to the facility, because of her elopement risk.

On 9/14/22 at 5:40am, V9 CNA, stated that when we work short staffed we are unable to do one on one supervision. V9 verified that R7 is on one on one because of exit seeking and elopement

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attempts. V9 stated that R7 has eloped before. V9 stated that R7 was anxious and pacing in the hall watching staff watch R7. V9 stated that she told V11 that R7 was up to something to keep an eye on R7 while we (V9, V10) do rounds. V9 stated that rounds were started at 2:00am, not long after that, R7 ran out the front door, V11 ran after her, but could not keep up. V9 verified that V11 ran back into the building, said that R7 ran towards the fields, so V9 and V10 went after R7, but could not find her. V9 stated that the police came and asked V9, V10 and V11 to search every room, which they did, R7 was not in the building. V9 stated that the police brought R7 back to the building around 3:15am. V9 stated that V14, Police Officer, stated that R7 was found sitting by a dumpster at a local restaurant about a mile away from the facility.

9/14/22 at 6:15am, V3, Assistant Director of Nursing/Licensed Practical Nurse, stated that R7 has been on one on one supervision since admission because of exit seeking and elopement attempts. V3 verified that R7 has actually got out the front door, but has come right back in. V3 stated that R7 will ask the same questions over and over, about 15 seconds apart. V3 verified that there were only three staff for the night shift on 9/9/22-9/10/22.

On 9/14/22 at 9:35am, V11, Registered Nurse, verified that R7 ran out the front door on 9/10/22 around 2:30am. V11 stated that she ran after R7, but could not see her when she got outside of the building. V11 stated that she called the police when she came back into the building and the two CNA's (V9 and V10) went to search for R7. V11 stated that the police brought R7 back around 3:15am. V11 stated that she sent a message to the "Boss" (V3 Licensed Practical

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S9999	Continued From page 5 Nurse) and called V16, R7's Family, after calling the police. V11 verified that there was not enough staff to do one on ones on 9/10/22, just make sure to do checks on the residents. On 9/14/22 at 7:20pm, V14, Police Officer, stated "I responded to a walkout at the facility at 2:11am. Myself and another deputy searched the bean field and cemetery east of the facility, but did not find (R7). Due to (R7's) history of elopements and suicide attempts, fire and rescue were called in on the search. (R7) was found about one mile away from the facility, sitting by a dumpster behind a restaurant, on a busy highway. I picked (R7) up and returned her to the facility. The staff at the facility wanted me to arrest (R7) because they did not have the staff to watch her. There were only three staff on duty at the facility. The call came in at 2:11am and (R7) was located at 3:11am." V14 stated that he has been called to the facility before concerning R7, leaving the building. On 9/13/22 at 2:00pm, V1, Administrator in Training, stated that the facility did not consider R7's leaving the building an elopement, because staff seen her go out the front door. V1 verified that R7 was not seen on the property, when staff searched for R7. On 9/13/22 at 2:30pm, V2, Cooperate Administrator, verified that R7's exiting the building was not considered an elopement. V2 verified that R7 was in the community at night by herself. V2 stated that staff "just do the best they can, when they are short staffed." (A)	S9999		