STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146097	A. Building B. Wing	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

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 34048 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 of five residents (R7), reviewed for elopement risk, in a sample of 10. These failures resulted in an immediate jeopardy. Findings include: These failures resulted in R7 not being adequately supervised and exiting from the facility on 9/10/22 at 2:30am. While the immediacy was removed on 9/15/22, the facility remains out of compliance at a Severity Level II as the facility implements the following: chart audits are completed and elopement assessments are completed, in-servicing all staff on policy and procedures, door alarm, elopement prevention, missing resident, emergency care/elopement, behavior tracking comprehensive care planning and resident monitoring policy including 1 on 1 policies are reviewed by the Quality Assurance team. 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. (continued on next page)

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R7's Elopement Risk Assessment, dated 8/12/22, documents a score of 5, indicating that R7 is a 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 court yard 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 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 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. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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. An Immediate Jeopardy situation was identified on 9/15/22. The Immediate Jeopardy began on 9/10/22 at 2:06am, when the facility failed to provide supervision to prevent a high risk elopement resident from leaving the building unattended. V1, Administrator in Training was notified of the Immediate Jeopardy on 9/15/22 at 4:20pm. The Surveyor confirmed through interview, observation and record review that the facility took the following action to remove the Immediate Jeopardy: All resident records were immediately audited for Current Elopement assessments and Risks levels on 9/16/2022 by nursing staff members. The Missing resident Binder was reviewed and all appropriate residents demographic information and photos were present. All staff were in-serviced on 9/16/2022 on all of the following policies and procedures. (Door Alarm Policy, Elopement Prevention Policy, Elopement Evaluation, Missing Resident Policy, Emergency Care/Elopement Policy, Behavior Tracking, Comprehensive Care Planning and Resident Monitoring Policy including 1 on 1) by the AIT and Resident Care Coordinator. R7's care plan was updated with interventions for elopement prevention, wandering and exit seeking. The quality assurance team will review compliance R7's daily.