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	09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
El Paso Health Care Center	850 East Second Street El Paso, IL 61738

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33960 Based on record review and interview, the facility failed to document Advanced Directives for one of five residents (R36) reviewed for Advanced Directives in the sample of 31. Findings include: The facility's Advance Directive policy, dated [DATE], documents, At the time of admission each resident, POA (Power of Attorney), guardian or responsible party shall be given written information regarding resident rights and advance directive. At this time, each resident/responsible party will be requested to furnish this facility with copies of all existing advance directives. The day of admission to this facility, the Social Service Designee, Administrator or designee at admission shall meet with the resident/responsible party to review existing advance directives. Any decision made by the resident shall be indicated in the chart in the manner easily understood by all staff. Advance directives specifying full code/Attempt Resuscitation/CPR, or the absence of determination shall be recorded as a Full Code. Code status shall also be recorded on the resident's Physician Order Sheet. R36's Physician's orders, dated ,d+[DATE]-[DATE], documents that R36 was admitted to the facility on [DATE]. However, the orders do not have documentation of R36's advanced directive code status. R36's POLST (Practitioner Order for Life-Sustaining Treatment Form) located in R36's current medical record is blank. On [DATE] at 11:33 AM, V3 (Cooperate Nurse) stated, (R36's) POLST is blank, and he does not have advanced directives documented on the chart.

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 33960 Based on observation, interview, and record review, the facility failed to perform daily and/or weekly skin checks on a resident at a high risk for developing pressure ulcer and assess a resident's skin condition. This failure affected one of two residents (R41) reviewed for pressure ulcers in the sample of 31. This failure resulted in R41's pressure ulcer being discovered at a Stage 3. Findings include: The facility Pressure Sore Prevention Guidelines, dated 1/18, documents, It is the facility's policy to provide adequate interventions for the prevention of pressure ulcers for residents who are identified as High or Moderate risk for skin breakdown as determined by Braden Scale. The nurse will complete a skin assessment on all residents upon admission then weekly for four weeks. After the weekly skin assessments are completed they must then be done with an annual, quarterly and significant change MDS or in the event a pressure ulcer develops. The following guidelines will be implemented for any resident assessed at a Moderate or High skin risk. The guidelines also document in a chart if a resident is at high risk for developing pressure ulcers daily skin checks will be performed, and if at moderate risk weekly skin checks will be completed. Also documenting, Any resident scoring a high or moderate risk for skin breakdown will have scheduled skin checks on the treatment record. Skin checks will be completed and documented by the nurse. On 8/29/22 at 11:45 a.m., R41 had an oval shaped open area with depth on his sacral area. R41's Braden Scale for Predicting Pressure Ulcer Risk assessments, dated 4/18/22 and 7/18/22, document that R41 is at a high risk for developing pressure ulcers. R41's TAR (Treatment Administration Record), dated 6/1-6/30/22, documents for the nurses to perform weekly skin care on Sundays. The TAR documents that this was completed three times during this time period on 6/5, 6/12, and 6/19/22. There is no documentation of daily skin checks being completed. R41's TAR dated 7/1-7/31/22, documents for the nurses to perform weekly skin care on Sundays. The TAR documents that this was completed once during this time period on 7/10/22. There is no documentation of daily skin checks being completed. R41's Nurses' notes, dated 8/3/22, documents, R41 has open area to buttocks. New order received apply collagen to buttocks then calcium alginate cover with border foam. R41's medical record has no documentation of an assessment being completed of R41's pressure ulcer when it was discovered on 8/3/22. R41's Wound Evaluation & Management Summary, dated 8/10/22, documents, (R41) has a Stage 3 pressure wound sacrum for at least 1 day duration. Stage 3 Pressure Wound Sacrum Full Thickness: Wound size: 2 x 0.7 x 0.2 cm (centimeters). Dressing treatment plan: Primary dressing: Alginate calcium with silver. Secondary dressing: gauze island with border daily. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R41's Pressure Ulcer care plan, dated 8/17/22, has no documentation of revision that R41 had developed a pressure ulcer. R41's Wound Evaluation & Management Summary, dated 8/24/22, documents, (R41) has a full thickness Stage 3 pressure wound to his sacrum that measures: 0.7 x 0.5 x 0.1 cm (centimeters). On 8/31/22 at 1:00 p.m., V9 (Corporate Nurse) stated, (R41) does not have an initial wound assessment. His wound was not fully assessed until he was seen by the wound doctor. When the wound was identified an AIMs for Wellness should have been completed that would have documented the full wound assessment and notified the physician. That was not done. If a resident is a high risk for developing pressure ulcers then daily skin checks should be documented on the TAR. V9 confirmed that daily skin checks were not done for R41 nor were all weekly skin checks.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. 31283 Based on interview and record review, the facility failed to ensure Certified Nursing Assistants received a minimum of 12 hours of in-service training in the past year, and dementia-specific training was administered. This failure has the potential to affect all 91 residents currently residing in the facility. Findings include: On 08/29/22, V1 (Administrator) provided copies of the facility's CNA (Certified Nursing Assistant) In-Service Training Records. V1 stated that the facility only has three full-time CNAs, due to having multiple staff members fill shifts from local staffing agencies. V7, V15, and V16's (Certified Nursing Assistant) In-Servicing Training Records did not include dementia-specific training was administered. V16's In-Service Training Record also documents that V16 has only received nine hours of training in the past 18 months (completed from 02/14/21 - 08/15/22) . The facility's Resident Census and Condition of Residents, dated 08/30/22 and signed by V1 (Administrator) documents that 91 residents currently reside in the facility.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. 31283 Based on interview and record review, the facility failed to ensure daily nurse staffing information was posted, and 18 months of nurse staffing records were maintained. This failure has the potential to affect all 91 residents currently residing in the facility. Findings include: On 08/29/22 at 2:50 PM, a facility-wide tour was conducted. On a bulletin board across from the nurse's station, a Daily Nursing Staffing Sheet was posted, and indicated the last date the staffing hours were completed was on 06/26/19. On 08/29/22 at 2:55 PM, V5 (Agency Wound Nurse) confirmed the last completed date for the Daily Nursing Staffing Sheet posted was 6/26/19. On 08/29/22 at 3:15 PM, V1 (Administrator) verified that a current Daily Staffing Sheet was not posted, and stated, We haven't been doing them. V1 then stated that since the facility has not been completing a Daily Staffing Sheet for quite some time, he is unable to provide 18 months of maintained records. The facility's Resident Census and Condition of Residents, dated 08/30/22 and signed by V1 (Administrator) documents that 91 residents currently reside in the facility.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 33960 Based on observation, interview, and record review the facility had no documentation to warrant the use of an antipsychotic medication for one of six residents (R34) reviewed for psychotropics in the sample of 31. Findings include: The facility's Psychotropic Medication Policy, dated 6/17/22, documents, It is the policy of this facility that residents shall not be given unnecessary drugs. Unnecessary drug is any drug used without adequate monitoring; without adequate indications for it's use. The policy also documents, Any resident receiving such medications shall have a psychiatric diagnosis or documented evidence of maladaptive behavior, which can be considered harmful to themselves or others, destructive to property, or if emotional problems exit which cause the resident frightful distress. The Behavioral Tracking sheet of the facility will be implemented to ensure behaviors are being monitored. Any resident receiving any psychotropic medication will have certain aspects of their use and potential side effects addressed in the residents' care plan at least quarterly. The care plan will identify target behaviors causing the use of psychotropic medications. The care plan will address the problem, approaches and goals to address these behaviors. On 08/28/22 at 8:16 AM, R34 was alert and oriented lying in his bed. R34 was pleasant and interacting appropriately with no behaviors exhibited. R34's Physician's orders, dated 8/1-8/31/22, documents that R34 has orders to receive Seroquel (antipsychotic) 500 mg (milligrams) by mouth at bedtime for the diagnoses of Insomnia, Depression, and Anxiety, and Seroquel 200 mg by mouth twice a day. R34's Care plan, dated 6/9/22, documents, R34 requires use of psychotropic medication to manage mood and/or behavior issues. Candidate for gradual dose reduction. Needs monitored for drug related complications. R34's care plan has no documentation of target specific behaviors and/or diagnoses to warrant the use of R34's antipsychotic. On 8/31/22 at 11:30 a.m., V3 (Cooperate Nurse) stated, There is no documented behavior tracking for (R36). I'm not sure what he is receiving this medication for.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33960 Based on interview and record review the facility failed to ensure a physician ordered laboratory values were obtained for one of one resident (R36) reviewed for laboratory values in the sample of 31. Findings include: R36's Physician's orders, dated 7/20-7/31/22, document that R36 was admitted on [DATE] with the orders to receive Folic Acid 1 mg (milligram) by mouth daily, Keppra 750 mg two tablets by mouth twice a day, and Lipitor 40 mg by mouth daily. The Physician's orders also document that an order was received on 7/22/22 to obtain the following laboratory values: Keppra, Folic Acid, and Lipid Panel. R36's medical record has no documentation of these laboratory values being obtained. On 08/31/22 at 12:44 PM V9 (Cooperate Nurse) stated, Those are all of the labs that we have for (R36). There is nothing else for him. V9 confirmed that the physician ordered Keppra, Folic Acid, and Lipid panel laboratory values were not obtained.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. 33960 Based on observation, interview, and record review, the facility failed to perform and document the food cooling process. This failure had the potential to affect all 91 residents residing in the facility. Findings include: The facility's Food Cooling policy, dated 3/2018, documents, It is the policy of the facility that TCS (Time Temperature Control for Safety) foods will be cooled properly to prevent the outbreak of food borne illness. Hot foods will be cooled to the proper temperature using a two stage cooling process. Stage 1: Cool foods from 135 degrees F (Fahrenheit) to 70 degrees F within two hours. Stage 2: Cool foods from 70 degrees F to 41 degrees F or below within four hours. (Total of six hours). If the food has not been cooled to 70 degrees F or below within the first two hours the food needs to be thrown out or reheated one time only to 165 degrees F for 15 seconds. The cooling process will start over using an alternate method to cool from what failed initially. If the food does not reach 70 degrees F or below the second time, the food item must be discarded. Use the Food Cooling Log for temperature monitoring and recording. The dietary manager will review and monitor the food cooling process and log for completion. The dietary manager will maintain records of the food cooling logs for one year. On 08/29/22 at 11:00 AM, V10 (Dietary Manager) stated, We do not do a cool down log because we never have leftovers. If we do we throw them away. The facility's Week 4 Week at a Glance menu documents for Monday (8/29/22) the noon meal is country fried steak, mashed potatoes, country gravy, broccoli and frosted cake. The menu also documents the day prior's (Sunday 8/28/22) noon meal was pot roast and vegetables. On 08/29/22 at 11:42 AM, V12 Cook had the steam table prepared and storing country fried steak, mashed potatoes, country gravy, broccoli, pot roast, French fries, and carrots. V12 stated, The pot roast is leftovers from yesterday's meal. What is the cool down process? I placed it in the refrigerator yesterday, but I didn't do any temperatures or anything. On 08/29/22 at 12:18 PM, V12 began to prepare meal trays. V12 scooped pot roast out and placed on meal tray. This surveyor had to stop V12 from serving the pot roast due to the meat not being cooled down properly. The facility's CMS (Centers for Medicare and Medicaid Services) Resident Census and Conditions of Residents Form 672, dated 8/30/22 and signed by V1 (Administrator), documents that 91 residents reside in the facility.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 33960 Based on observation, interview, and record review, the facility failed to monitor the level of sanitizing solution of the facility dishwasher and three compartment sink, and monitor the temperatures of the refrigerators and freezers, provide and follow a cleaning schedule for all kitchen tasks to maintain a clean ceiling, hood range, refrigerator fans, ceiling vents, air wall fan and dishwashing room wall fan. This failure had the potential to affect all 91 residents residing in the facility. Findings include, The facility's Kitchen Sanitation policy, dated 10/20, documents, The Food Service Manager will monitor sanitation of the Dietary Department on a daily basis. The Food Service Manager will develop a cleaning schedule for the department and ensure that dietary employees complete cleaning tasks as scheduled. The facility's dish machine policy, dated 10/09, documents, For low temperature dish machines (temperature of wash water shall not be less than 120 degrees Fahrenheit) Before washing anything, use a test strip to check the sanitizer level. Record either the temperatures or sanitizer level on the dish machine Temperature/Sanitizer log. On 08/29/22 at 10:51 AM, The facility's Vegetable Freezer Temperature log, dated 8/2022, was hanging on the outside of the freezer. The log had no documentation of temperatures being checked on 8/27-8/28/22. V10 (Dietary Manager) stated, Refrigerator and freezer temperature checks are supposed to be done every day. There is no temperatures for the 27th or 28th. On 08/29/22 at 10:56 AM, the facility oven hood had a wet fuzzy looking residue scattered throughout it above the cooking surface. The ceiling tiles throughout the kitchen had a fuzzy gray substance hanging from them. V10 stated, That's greasy dust on the hood. I just started and this kitchen really needs cleaned. On 08/29/22 at 10:58 AM, the exit to the outside doors located in the kitchen had an air curtain fan attached to the top of them that forcefully blew out air downward constantly. The inside of the fan was covered with a black fuzzy substance. V10 confirmed the dust on the fan. On 08/29/22 at 10:58 AM, the facility dry food storage room had two air conditioning vents in the ceiling that were covered with a gray fuzzy substance. V10 confirmed the dust on the vents. On 08/29/22 at 11:00 AM, the walk in cooler had a fuzzy black residue scattered on the roof of the cooler. The cooler also had two fans blowing over a rack filled with cups of orange juice, cranberry juice, apple juice, and thickened juices. The fan blades and fan covers had fuzzy black substance scattered throughout them. V10 confirmed that the fans were blowing over the drinks prepared for the lunch meal. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 08/29/22 at 11:07 AM, The August 2022 Dishwasher Temperature/Sanitizer log was hanging on a refrigerator near the dishwasher. The log had no documentation of the sanitizer level or temperatures being checked on: 8/19 lunch and supper, 8/20-24 supper, 8/25 lunch and supper, 8/26 breakfast, lunch and supper, 8/27-28 supper. The log also documents, Record temperature or test strip results before washing dishes after each meal. V10 stated the sanitizer levels should be checked before every meal, and confirmed the holes on the log. On 08/29/22 at 11:09 AM there was a large fan attached to the wall in the dishwashing room. The fan blades and fan cover had a fuzzy black substance scattered throughout them. The fan was on and blowing over clean dishes. V10 confirmed the dust on the fan. The facility's CMS (Centers for Medicare and Medicaid Services) Resident Census and Conditions of Residents Form 672, dated 8/30/22 and signed by V1 (Administrator), documents that 91 residents reside in the facility.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 32061 Based on record review and interview, the facility failed to ensure the Quality Assurance and Performance Improvement (QAPI) committee held meetings at least quarterly as outlined in their Quality Assurance and Quality Improvement Plan. This failure has the potential to affect all 91 residents residing in the facility. Findings include: The facility's undated QAPI (Quality Assurance Performance Improvement) documents the following: All department managers, the Administrator, the Director of Nursing, Infection Control and Prevention Officer, Medical Director, consulting Pharmacist, resident and/or family representatives (if appropriate) and three additional staff will provide QAPI leadership by being on the QAA (Quality Assurance Agency) committee. The QAA committee will meet monthly. On 08/28/22 at 09:48 AM, V3/Corporate Nurse stated the following: 7/11/2022 is the first scheduled QA meeting, I can find sign in sheets for, for the past year. V3 confirmed that the facility has not been holding QA meetings quarterly. The Centers for Medicare and Medicaid (CMS) Resident's Census and Condition of Residents Report, form 672, dated 8/30/2022 documents that at the time of the survey 91 residents lived in the facility.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 33960 Based on observation, interview, and record review, the facility failed to maintain the kitchen without insects. This had the potential to affect all 91 residents residing in the facility. Findings include: The facility's Insect and Pest Control Policy, no date available, documents, It is the policy of the facility to contract with a duly licensed exterminating service to protect and/or control against infestations of insects and rodents. Any employee observing insects or rodents of any kind shall inform their supervisor giving the exact location and type of infestation. The employee shall fill out a work order form and give it to the maintenance person. The maintenance person shall contact the contracted pest control company for eradication. On 08/29/22 at 10:50 AM, multiple soiled towels were lying on the floor underneath of the kitchen preparation table. Ants were crawling on the floor on the towels and around them on the floor. Multiple gnats and flies were also flying around the preparation area landing on the counters and on the towels. V10 stated, The towels should not be on the floor. Yes, those are ants, gnats, and flies. On 08/29/22 at 11:57 AM, multiple flies were on the wall above the steam table with uncovered mashed potatoes, gravy, pot roast, broccoli, and French fries. The facility's pest control Summary of Service, dated 8/5/22, documents the following kitchen recommendations: High Severity (New) Door gap/damage noted that allows pest access. Please repair to prevent pest entry; High Severity (New) An accumulation of food product from damaged goods noted. Please remove food product to prevent attraction by pests. Under dishwashing sinks. On 9/01/22 at 08:29 AM, V13 (Maintenance Supervisor) stated, I was aware we had flies but I was not aware of the ants. I should be notified of that immediately because I have stuff available to use immediately. However, the ants are attracted to their soiled towels especially if they leave them laying on the floor. There is an enclosed barrel they should be placing all of those towels in that will avoid the ants being attracted to them. When the pest control person comes they leave as report for us of what they have done and any concerns. When they come back they will address the concern again, but will mark complete if it was taken care of. The door gap in the kitchen is an ongoing thing. The kitchen staff go in and out of that door constantly and the door threshold gets damaged. The facility's CMS (Centers for Medicare and Medicaid Services) Resident Census and Conditions of Residents Form 672, dated 8/30/22 and signed by V1 (Administrator), documents that 91 residents reside in the facility.