

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145319	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2024
NAME OF PROVIDER OR SUPPLIER Arc at El Paso		STREET ADDRESS, CITY, STATE, ZIP CODE 555 East Clay 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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31283</p> <p>Based on interview and record review, the facility failed to provide supervision to a resident identified as an elopement risk, who had been exhibiting an increase in verbalizations of exit seeking behavior. On the morning of 05/18/24, R1 removed his (elopement alert bracelet) and exited the facility unnoticed. R1 was later found propelling his wheelchair approaching a road containing a high volume of traffic. R1 was one of three residents reviewed for wandering/elopement in the sample of three.</p> <p>These failures resulted in an Immediate Jeopardy.</p> <p>While the immediacy was removed on 07/10/2024, the facility remains out of compliance at a Severity Level two as additional time is needed to evaluate the implementation and effectiveness of the removal plan including their In-service training and Quality Assessment oversight.</p> <p>Findings include:</p> <p>The facility's 'Code Pink- Missing Resident/Elopement' policy (revised 04/2023) documents, The facility maintains a process to assess all residents for risk for elopement, implement risk reduction strategies for those identified as an elopement risk, and institute measure for resident identification at the time of admission. Elopement is the ability of a cognitively impaired resident who is not capable of protecting himself or herself from harm, to successfully leave the facility unsupervised and unnoticed and who may enter into harm's way. This same policy documents, Risk Reductions Measures: Interventions that may be used for residents identified as high risk for elopement include: Frequent monitoring of the resident's whereabouts to assure he or she remains in the facility; room placement close to common areas such as the nurse's station and away from exits; promoting activities that are in full view of staff members; Alternative activities to maintain the interest level of the wanderer; Implementation of wander bracelet or other electronic alert systems, transfer to a more suitable or more secured unit/facility, if needed. This policy also documents, Verification of control systems: If an electronic surveillance system is in place, door alarms are tested weekly for proper functioning and the testing is documented; Door alarm codes are changed routinely; Resident electronic monitoring sensors are checked every shift for placement and daily for proper functioning and documented in the Resident Record, Treatment Administration Record, Medication Administration Record, or a specifically designed log.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>R1's Medical Record documents R1 was admitted to the facility on [DATE] with the following diagnoses: Urinary Tract Infection, Major Depressive Disorder, Vascular Dementia, and Delusional Disorder.</p> <p>R1's Elopement Risk Assessment (dated 05/13/24) documents a score of 8, indicating R1 is, at risk to elope and should be placed on the Elopement Risk Protocol. A care plan for elopement is indicated.</p> <p>R1's Elopement Risk/Wanderer care plan (dated 05/13/24) documents R1 is at risk for elopement and documents the following interventions: 1:1 monitoring. IDT (interdisciplinary team) to discuss and re-evaluate; Assess for fall risk; Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book; Identify pattern of wandering- Is wandering purposeful? Does it indicate the need for more exercise? Intervene as appropriate; Provide 1:1 supervision with staff; Provide structured activities- toileting, walking inside and outside, reorientation strategies including signs, pictures and memory boxes.</p> <p>R1's Physician Order (dated 05/21/24) documents the following order: Ensure (elopement alert bracelet) is attached to right ankle every shift and night shift to test function.</p> <p>R1's Treatment Administration Record (dated May 2024) documents R1's elopement alert bracelet was not checked on the day shift of 05/18/24 and was last checked at some point during night shift on 05/17/24.</p> <p>R1's Progress Note (dated 05/13/24) documents: (R1) was assessed for elopement/unauthorized leave. The resident does not have a history of wandering/elopement and does not verbalize a strong desire to leave. The resident has a diagnosis of dementia and/or severe mental illness. Resident has reported or documented episodes of elopement and/or attempts to elope. The resident's representative (i.e., Health Care Power of Attorney, close family member, guardian) has requested that the resident be monitored on the Elopement Protocol. Behavioral Observations include: Verbalizes a serious/strong intent to leave the facility in the absence of an appropriate discharge plan. Responds poorly to staff re-direction when roaming into areas that are off limits or unauthorized. Has the physical ability to leave the building. Becomes agitated, confused and/or disoriented or displays consistently poor judgement (would not be able to safely care for him/herself outside of the facility). Resident is at risk to elope and should be placed on the Elopement Risk Protocol. A care plan for Elopement is indicated.</p> <p>On 07/03/24 at 10:30 AM, V11 (Social Service Director) stated R1's cognition would fluctuate from day to day, He could always answer the questions from the BIMS (brief interview for mental status) assessment correctly and would score 15 (indicating cognitively intact), but there were several instances when he could not recall a conversation I had with him the previous day. I had multiple conversations with him about why he had a court-appointed guardian. He would then ask me the same thing the following day and could not recall the same conversation we'd had about it from the day before.</p> <p>R1's Progress Note (dated 05/18/24), written by V1 (Administrator), documents, Resident (R1) noted to have exited facility, no alarm sounded. Staff approached resident and attempted to redirect back to the facility; these attempts were unsuccessful. 911 called and (R1) resisted and was aggressive towards emergency personnel before being sent to (local hospital) for evaluation. No injury noted. Guardian and physician notified.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 07/02/24 at 01:35 PM, V3 (Certified Nursing Assistant) stated the following regarding R1's 05/18/24 elopement, I know it was on a weekend sometime in May. I was told he made it a couple of blocks. He was close to Route 24, which is a pretty busy road. He would say that he was going to leave daily. I heard he cut his (elopement alert bracelet) off and then left. I don't think the alarm sounded since he wasn't wearing his (elopement alert bracelet). He was pretty well in his right mind most of the time. The code to exit the building used to be posted next to the keypad in the breezeway near the front door, so he probably just entered the code to get out. I know they had to change codes to some of the other doors because he knew the code to unlock and open them. When (R1) got out of the building, he was in his wheelchair, and I believe someone in a car spotted him and notified the facility. I believe (V4, Certified Nursing Assistant) and (V5, Registered Nurse) left the building to find him.</p> <p>On 07/02/24 at 02:00 PM, V6 (Certified Nursing Assistant) stated, (R1) got out of the building on 05/18/24. He kept saying to that he was going to leave. I know he told (V7, Certified Nursing Assistant) that he was leaving on that same morning before he eloped. From what I have been told, (R1) got out alone and nearly made it to Route 24, and that is a very busy road. I am not sure how he was found.</p> <p>On 07/02/24 at 02:10 PM, V4 (Certified Nursing Assistant) stated she was working on 05/18/24 when R1 eloped from the facility. V4 stated, We were getting ready to serve breakfast, and I got a message from (V8, Certified Nursing Assistant) on our work communication messaging app. The message said, '(V5, Registered Nurse) and I (V8) are on (Route) 24 with (R1).' I tried calling (V5 and V8) and got no answer from either one of them. A few minutes later, I told the other staff in the building I was going to go find them. I got in my van and headed toward (Route) 24. I didn't see them, so I sent a text to (V8) for their location, and she responded that they were up by (Route) 24 on the side road towards (nearby town). When I found them, (R1) was very agitated, and shortly after I got there, the police showed up followed by an ambulance. V4 then stated, (R1) must have gotten out the front door. He was in his wheelchair and made it down to the corner, turned left and headed toward Route 24. I believe some lady driving saw him and notified the facility.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 07/02/24 at 02:30 PM, V8 (Certified Nursing Assistant) stated she was one of two staff members that were first to locate R1 on 05/18/24 after he had eloped from the facility. V8 stated, It was about 08:00 AM and we were serving breakfast. I was up front in the lobby. (R1) likes to sit up front near the entrance to the building in the living room. I was talking to (V5, Registered Nurse), and a lady came in the front door. She told us she was driving and saw a man in a wheelchair on the road. She said that she had stopped to check on the man and he told her he was going home, so she decided to drive here and come inside to alert someone. (V5) and I got in her car and found (R1) propelling his wheelchair a couple blocks away. He had almost made it up to Route 24. He was actually very close, and that road is very busy with traffic. He was in his wheelchair, and he was very agitated because we had found him. We called (V1, Administrator) and (V2, Director of Nursing), and they talked to (R1) and basically explained his options. He remained agitated, so (V5) called 911. Two police officers showed up and then an ambulance. (R1) was sent to the emergency room and they (medics) had to sedate him to get him into the ambulance. (R1) somehow got his (Elopement alert bracelet) off. I heard he cut it off, and then he entered the code to exit the building since it used to be posted on the wall next to the keypad by the front door. It has since been changed. (R1) is alert enough to know how to enter the code to unlock the door. At some point, I had messaged (V4, Certified Nursing Assistant) to let her know where (V5) and I were because we had been out of the building for at least 30 minutes, and I knew people were going to start wondering where (V5) and I were at. (V4) came to where we were in the road in her van, and we loaded (R1's) wheelchair in her van when (R1) was taken to the hospital. V8 stated she was never asked to give a witness statement about the incident, No one ever talked to me about it, and I thought that was a little weird.</p> <p>On 07/03/24 at 09:35 AM, V5 (Registered Nurse/Former Manager on Duty) stated she is one of the staff members that responded after R1 eloped from the facility on 05/18/24. V5 stated, I remember I was on the phone with a resident's family member about lab results. A lady from the community came in the building and told (V8, Certified Nursing Assistant) that there was a man in a wheelchair going down the road. (V8) and I got in my car and located (R1). He was agitated that we had found him, and he was dead set that he was going home. I called (V1, Administrator) and (V2, Director of Nursing). Both tried talking to (R1) and he still refused to return, so 911 was called. The police arrived and then the medics. (R1) was combative with them and had to be sedated before they transported him to the hospital. While we were standing in the road, I noticed he did not have his (elopement alert bracelet) on his wheelchair. I asked him where it was, and he would not tell me. When he returned from the hospital a couple days later, he told me he had found a pair of scissors in the receptionist's desk drawer, cut the bracelet off, and threw it in a drawer with the scissors. I went and checked the drawers in the front living room, and there sat a pair of scissors and a cut (elopement alert) bracelet. (R1) had made it very close to Route 24. If that lady wouldn't have come when she did, it could have turned really ugly. I believe (R1) would have attempted to cross that road, and it's a road that is very, very busy with traffic. V5 stated she was never asked to give a witness statement or provide any details of the incident after it had occurred. V5 stated R1 was alert and oriented most of the time, but did exhibit some confusion about going home, He did not understand why he had a court-appointed guardian, and this had been explained to him often. At times, (R1) would get into a state of mind where he was not making safe, rational decisions. Before he got out of the building, he kept talking about leaving. He knew the code to exit the dining room door that led to the courtyard, and since he was not allowed outside by himself after the incident, the code to exit the dining room door was changed. The code to the front door used to be posted right next to the keypad where you enter the code to unlock it. I am sure this is how (R1) got out, the code was posted so all he had to do was type it in on the keypad. That code had to be changed after all of this occurred.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 07/03/24 at 10:55 AM, V7 (Certified Nursing Assistant) stated she was working on 05/18/24 when R1 eloped. V7 stated, I talked to him early that morning when he was in his room. I asked him how he was doing, and he said 'OK.' He told me not to worry about his stuff because it's all packed up, and I saw that all of his personal items were packed in a black garbage bag. He then told me that he was going to leave that day. He said, 'right after breakfast I'm going to head out those doors.' I told (V12, local agency Licensed Practical Nurse), who was working in the East Hall that day. I never saw (V12) go and start checking on (R1) frequently after I had reported all of this to her. She really didn't do anything after I told her.</p> <p>On 07/03/24 at 03:00 PM, V12 (local agency Licensed Practical Nurse) stated she recalls the day when R1 eloped from the facility, I had never worked with that resident (R1) before. I was told he had been saying he was going to leave and go home. One of the CNAs (V7) told me that he told her he was leaving after breakfast and that he had all of his bags packed in a garbage bag. I saw him when he was heading to the dining room. I went ahead and gave him his medications, and that was the last time that I saw him. The manager on duty (V5, Registered Nurse) was aware of what he was saying and told me she had spoken with (R1), so I continued on with my medication pass. V12 stated, I haven't worked at that facility much, but I do remember the code to unlock the door is posted right by the keypad in the entryway.</p> <p>On 07/03/24 at 08:15 AM, V1 (Administrator) confirmed R1 eloped from the facility on 05/18/24 and stated, It happened on the weekend. The alarm didn't give warning and (R1) went through the door. I believe he was about half a block away. When staff found him, he was very noncompliant and wasn't rationalizing with anyone. 911 was called and (R1) was sent to the hospital for a psychiatric evaluation. He was placed on 1:1 supervision when he returned to the facility. I believe someone from the community alerted staff in the building that a man was propelling his wheelchair down the road. V1 stated an incident investigation was not completed after R1's elopement, and therefore, he cannot provide an investigation for review.</p> <p>On 07/03/24 at 12:55 PM, V2 (Director of Nursing) stated that R1 eloped on a day during the weekend, and she was not at the facility when it occurred. V2 stated, I got a call from (V5, Registered Nurse) and she told me that she was outside of the building with (R1). I could hear (R1) in the background saying he wanted to go home. He lived in (nearby town), which is at least a 30-minute drive from the facility. I asked him to return to the facility with (V5) and told him that if he was not willing to return, EMS (emergency medical services) would be contacted to handle the situation. 911 was then called and R1 was taken to the hospital. I did find out later that he told (V5) that he cut his (elopement alert bracelet). V2 stated there was no type of investigation completed on R1's 05/18/24 elopement incident because, he wasn't harmed from what I understand from the regulations. V2 stated, (R1) has some periods of confusion. He couldn't understand why he couldn't just leave the building and wheel himself back to his hometown. There were multiple conversations that had to be repeated because he couldn't recall the same conversation that occurred the day before. He lacked safety awareness.</p> <p>On 07/08/24 at 08:50 AM, V2 (Director of Nursing) stated an intervention should have been implemented on 05/18/24 when R1 was making statements of leaving the building. V2 stated, If he had his bags packs and he was verbalizing a plan, I would expect staff to put him on 1:1 supervision.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 07/08/24 at 09:00 AM, V5 (Registered Nurse/Former Manager on Duty) stated, I was the Manager on Duty when (R1) eloped. I remember seeing (R1) in the dining room. I believe one of the CNAs (V7) reported to the nurse (V12) who then came to speak with me. I do recall speaking with (V12) about (R1). He was out in a common area, so he was never put on 1:1 supervision.</p> <p>The Immediate Jeopardy was identified on 07/09/24 at 10:20 AM to have begun on 05/18/24 when R1 verbalized he was going to leave the facility and no additional supervision was provided.</p> <p>V1 (Administrator) and V2 (Director of Nursing) were notified of the Immediate Jeopardy on 07/09/24 at 10:28 AM.</p> <p>The surveyor confirmed through interview, observation and record review that the facility took the following actions to remove the Immediate Jeopardy:</p> <p>On 07/10/24, V1 (Administrator) and V2 (Director of Nursing) were interviewed and spoke in detail about the facility's abatement plan.</p> <p>On 07/10/24, R1's most current medical record was reviewed and documents the following was completed upon R1's return from (local hospital) on 05/21/24: R1 was assessed by nursing and no pain or skin issues were identified; R1 was reassessed for risk of elopement and community survival skills; R1 was placed on 1:1 supervision that later decreased to 15 minute checks which was documented on 24 Hour/15 Minute Monitoring logs. This documentation was reviewed weekly by V2 (Director on Nursing) until R1 was discharged from the facility.</p> <p>On 07/03/21, V1 (Administrator) stated that an individual from maintenance came to the facility on [DATE] to check the door alarm's functional status and the front door alarm code was changed at that time. V1 stated that the keypad code posting was taken down and would no longer be posted in the front breezeway near the keypad that unlocks the front door. V1 then provided copies of forms titled 'Daily Maintenance Tasks' (dated 05/13/24 - 07/07/24), which indicate that maintenance staff have checked the functionality of the exit door and elopement alert bracelet alarm system daily during this time frame.</p> <p>On 07/10/24, V1 provided documentation indicating that V11 (Social Service Director) reviewed all facility resident's most current Elopement Risk Assessments for accuracy, and on 07/09/24, V11 completed a new Elopement Risk Assessment on every resident in the facility. V1 also stated that all residents will be evaluated for elopement risk at admission, readmission, quarterly, annually, with a significant change, and incidentally if risk behaviors are identified. V1 stated V11 is responsible for conducting these assessments, and a six-week audit is being conducted by V1. V1 provided copies of the Weekly Audit forms (dated 05/24/23 - 07/05/23) that have been completed.</p> <p>On 07/10/23, V1 provided copies of Elopement Drill/Post-Elopement Checklist logs that were completed on 05/18/24 and 07/03/24.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 07/10/23 at 10:00 AM, V1 stated that nursing staff check residents with elopement alert bracelets each shift to ensure the bracelet is in place. V1 stated elopement alert bracelets are also checked for functionality daily by nursing and maintenance, and facility staff as well as agency staff have binders to access at the nurse's station. On 07/10/24 at 12:40 PM, a binder labeled Agency Staff Orientation was accessible at the nurse's station and contained the facility's Elopement Device policy (dated 09/2019), and Code Pink-Missing Resident/Elopement policy (dated 04/2023). At this same time, a binder labeled, Exit Seeking Residents, contained an Exit Seeking Profile, A current Face Sheet, and a large color photograph of all residents who have been identified as elopement risks. R2 and R3's medical records were reviewed and indicate staff have been checking their elopement alert bracelets for placement and functionality as indicated.</p> <p>On 07/10/23, V1 provided copies of Attendance Sign-In Sheets for the following in-services: Elopement Policy & Procedure, Identifying Risks of Elopement, Wandering/Exit Seeking Behavior, and When to Provide/Implement Increased Supervision (Initiated on 05/18/24); Elopement and (Elopement Alert Bracelets), (initiated on 05/18/24); 1:1 Supervision (specific to nursing staff who provide 1:1 supervision, initiated on 05/24/24); Supervision of Elopement Risk Residents Outdoors (initiated on 06/06/24). These forms contained facility staff member's signatures confirming attendance, and these forms also document 30 staff members were called on 07/09/24 and given the in-service per telephone conversation.</p> <p>On 07/10/24, the following staff members were interviewed and indicated receiving the above noted in-servicing in May 2024: V15 (Licensed Practical Nurse); V18 (Registered Nurse); and V3, V21, and V24 (Certified Nursing Assistants).</p> <p>On 07/10/24 at 10:50 AM, V16 (Certified Nursing Assistant) stated he was called by someone at the facility on 07/09/24 and was given in-servicing and education over the phone at that time.</p> <p>On 07/10/24 at 10:52 AM, V17 (Activity Aide) stated she received instructional training, I was told (R1) was placed on 1:1 supervision, so I know he had a sitter. I only work twice a week, so I did not attend any education in-services back in May when (R1) left the building.</p> <p>On 07/10/24 at 11:15 AM, V19 (Receptionist/Hairdresser) stated, I am going to be honest with you. I just received training about elopement this morning (07/10/24). My phone was not available last night, but I did see that someone tried to call me. I knew that (R1) left the building and I knew the door code had been changed. This morning is the first time that I have received education from anyone about the incident. The elopement policy and protocol, who to contact, how to handle a situation with someone trying to leave the building, the chain of command to report to, and resident behaviors were the topics discussed with me this morning.</p> <p>On 07/10/24 at 11:35 AM, V20 (Housekeeping) stated he just received training regarding elopement on 07/09/24, They called me yesterday and told me everything over the phone and then someone talked to me when I arrived at work this morning.</p> <p>On 07/10/24 at 12:05 PM, V22 (Dietary Cook) stated she was called yesterday and given training pertaining to elopement and supervision over the phone.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 07/10/24 at 01:35 PM, V23 (Certified Nursing Assistant) stated she knew about the elopement that occurred on 05/18/24 and was aware R1 was on 1:1 supervision for a period of time after he eloped from the building. When asked if she had received education after R1's elopement V23 stated, I was called yesterday (07/09/24) and given education over the phone. That is the first time I have received education about the elopement.</p> <p>On 07/10/24, V1 provided a copy of the facility's Quality Assurance form titled 'Ad Hoc Quality Assurance (Plan of Correction)' which was completed on 05/21/24 regarding the facility's elopement policy and procedure, and indicated responses for each of the following questions: The problem?, How the problem is to be corrected and when will it be corrected?; and What is going to happen to ensure the problem will not happen again? How will this be monitored, by whom and how often? V1 then stated the facility's next Quality Assurance Meeting is scheduled for 07/25/24, and elopement/supervision will be discussed at this meeting and will continue to be reviewed during the next four quarterly meetings.</p>		