

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  146097	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/22/2024
NAME OF PROVIDER OR SUPPLIER  El Paso Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38805</p> <p>Based on interview and record review, the facility failed to ensure resident to resident physical abuse did not occur for two residents (R6, R7) of four residents reviewed for abuse in a sample of four.</p> <p>Findings include:</p> <p>Facility's Abuse Prevention and Prohibition Policy Revised 1/2024, documents: Each resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals.</p> <p>Facility's Initial and Final Reports to (State Department of Public Health) for R6 and R7 document: After investigation of the incident between residents (R6) and (R7) it has been determined that that R6 made physical contact with R7. R6 has been education on appropriate communication with fell ow residents and to keep hands to himself. R6 and R7 have been sitting in separate areas in the facilities dining hall. There have not been any further incidents between R6 and R7. R7 states feeling safe in the facility.</p> <p>R6's diagnoses include: Mild neurocognitive disorder due to known physiological condition with behavioral disturbance, manic episode severe with psychotic symptoms, family history of alcohol abuse and dependence.</p> <p>R6's Minimum Data Set/MDS dated [DATE] documents R6 has a BIMS (Brief Interview of Mental Status) of 8 on a scale of 00 - 15. (MDS indicates that on a scale of 0 - 15, 13 to 15 cognitively intact; 8 to 12 moderate impairment; and 0 to 7 severe impairment.)</p> <p>R6's current Care Plan documents: The resident is/has potential to be physically aggressive when he feels provoked by another resident related to History of harm to others.</p> <p>R7's diagnoses include: Bipolar disorder, suicidal ideations, psychophysiologic insomnia, attention-deficit hyperactivity disorder, anxiety, post-traumatic stress disorder/PTSD, schizoid personality disorder, major depressive disorder.</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R7's Minimum Data Set/MDS dated [DATE] documents R7 has a BIMS score of 15 on a scale of 00 - 15.</p> <p>R7's current Care Plan documents: The resident is known to display fluctuations in mood related to PTSD, bipolar, suicidal ideation, schizoid personality, insomnia, anxiety.</p> <p>On 5/21/24 at 11:40am, R6 stated that he does not remember details of the incident with R7 on 5/15/24; stated that he did not get hurt and had no injuries.</p> <p>On 5/21/24 at 12:05pm, R7 stated: Is this about the fight? R7 stated that at the time of the 5/15/24 altercation with R6, that he was shocked when R6 hit him and that he was still processing what went on.</p> <p>At this same time, R7 stated, We were at lunch and (R6) hit me in my chest and started hitting me when I touched (R6) on his shoulder; I thought (R6) was going to steal my food, that happens; and (R6) turned around and started hitting me.</p> <p>On 5/21/24 at 1:10pm, V14 Registered Nurse/RN, stated that she was the Nurse for R6 and R7 and witnessed the 5/15/24 incident; stated that R6 went to sit in R7's chair where R7's meal was. Stated that R7 said to R6, That is my dinner; (R7) gets confused at times, and started sitting down anyway. Stated that R6 said to R7, Okay punk!, and then struck R7 in his abdomen and on his back.</p>

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38805</b></p> <p>Based on interviews and record review, the facility failed to follow its abuse policy for a thorough investigation for two residents (R6, R9) of four residents reviewed for allegation of resident to resident abuse in a sample of four.</p> <p>Findings include:</p> <p>The facility's Abuse Prevention and Prohibition Policy Revised 1/2024, documents: Each resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. The facility Administrator will ensure a thorough investigation of alleged violations of individual rights and document appropriate action. Complete a thorough investigation. Two management level staff will conduct interviews with witnesses or other staff, residents or visitors who could have knowledge of the allegation. Witnesses will be asked to assist with completing statements if indicated. Every employee will be interviewed who was working on the specific hall/wing that the affected resident resides on.</p> <p>R6 and R9's AIM/Assess, Intercommunication, Manage for Wellness Event Record Progress Note dated 5/13/24 documents: (R6) appears to have been involved in an altercation with a peer. Event was first noted on 05/13/2024 12:35pm. Just prior to/at the time of the event R6 appears to have been sitting in the dining room awaiting lunch. R6's account of the event is R6 states other res (R9) just came up and started swinging at him; verbal altercation escalated into a physical altercation. Facility staff actions/interventions and response at time of the event includes residents separated immediately, assessment completed.</p> <p>There were no documentation to indicate that information regarding this resident to resident abuse allegation was reported sent to (State Department of Public Health) for R6 and R9.</p> <p>R6's diagnoses include: Mild neurocognitive disorder due to known physiological condition with behavioral disturbance, manic episode severe with psychotic symptoms, family history of alcohol abuse and dependence.</p> <p>R6's Minimum Data Set/MDS dated [DATE] documents R6 has a BIMS (Brief Interview of Mental Status) of 8 on a scale of 00 - 15. (MDS indicates that on a scale of 0 - 15, 13 to 15 cognitively intact; 8 to 12 moderate impairment; and 0 to 7 severe impairment.)</p> <p>R6's current Care Plan documents: The resident is/has potential to be physically aggressive when he feels provoked by another resident related to History of harm to others.</p> <p>R9's diagnoses include: Acute hepatitis-C, alcohol use, unspecified with alcohol-induced persisting dementia, schizoaffective disorder, Parkinson's disease with dyskinesia.</p> <p>R9's Minimum Data Set/MDS dated [DATE] documents R9 has a BIMS (Brief Interview of Mental Status) of 14 on a scale of 00 - 15.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R9's current Care Plan documents: (R9) is noted to have inappropriate behaviors and responses such as spitting on/toward staff and peers, knocking over ice carts and laundry carts.</p> <p>On 5/22/24 at 9:35am, V17 Certified Nursing Assistant/CNA stated that she was the caregiver for both R6 and R9 on 5/13/24; stated that she saw R6 and R9 sitting at table and both were talking. V17 CNA stated that R9 picked up a tea cup and threw it at R6 and R6 then threw his cup and hit R9.</p> <p>On 5/22 at 9:50am, V1 Administrator stated for the population at the facility, incidents happen and residents might have an altercation, and check with them later and everything seems to be fine. V1 stated that he talked with R6 and R9 and decided not to investigate further. V1 stated that he did not get interviews or witness statements from staff or residents for this incident.</p> <p>At this same time, V1 Administrator stated, There were no changes in their (R6 and R9) conditions; they said they were okay, so this was not investigated further.</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>38805</p> <p>Based on interviews and record review, the facility failed to report allegations of abuse to the State Agency for two residents (R6, R9) of four residents reviewed for allegation of resident to resident physical abuse in a sample of four.</p> <p>Findings include:</p> <p>The facility's Abuse Prevention and Prohibition Policy Revised 1/2024, documents: The facility Administrator will ensure a thorough investigation of alleged violations of individual rights and document appropriate action. Complete a thorough investigation. Two management level staff will conduct interviews with witnesses or other staff, residents or visitors who could have knowledge of the allegation. Witnesses will be asked to assist with completing statements if indicated. Every employee will be interviewed who was working on the specific hall/wing that the affected resident resides on. The facility Administrator, employee, or agent who is made aware of any allegation of abuse or neglect shall report or cause a report to be made to the mandated stated agency per reporting criteria.</p> <p>R6 and R9's AIM/Assess, Intercommunication, Manage for Wellness Event Record Progress Note dated 5/13/24 documents: (R6) appears to have been involved in an altercation with a peer. Event was first noted on 05/13/2024 12:35pm. Just prior to/at the time of the event R6 appears to have been sitting in the dining room awaiting lunch. R6's account of the event is R6 states other res(R9) just came up and started swinging at him; verbal altercation escalated into a physical altercation. Facility staff actions/interventions and response at time of the event includes residents separated immediately, assessment completed.</p> <p>On 5/21/24 at 12:50pm, V1 Administrator stated: We are supposed to send (State Department) reports whenever there is physical altercation, regardless if there is an injury or not. V1 stated that they did not report the altercation between R6 and R9 to (State) authorities.</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>38805</p> <p>Based on interviews and record review, the facility failed to do a thorough investigation for an allegation of resident to resident abuse for two residents (R6, R9) of four residents reviewed for abuse in a sample of four.</p> <p>Findings include:</p> <p>The facility's Abuse Prevention and Prohibition Policy Revised 1/2024, also documents: The facility Administrator will ensure a thorough investigation of alleged violations of individual rights and document appropriate action. Complete a thorough investigation. Two management level staff will conduct interviews with witnesses or other staff, residents or visitors who could have knowledge of the allegation. Witnesses will be asked to assist with completing statements if indicated. Every employee will be interviewed who was working on the specific hall/wing that the affected resident resides on. The facility Administrator, employee, or agent who is made aware of any allegation of abuse or neglect shall report or cause a report to be made to the mandated stated agency per reporting criteria.</p> <p>R6 and R9's AIM/Assess, Intercommunication, Manage for Wellness Event Record Progress Note dated 5/13/24 documents: R6 appears to have been involved in an altercation with a peer. Event was first noted on 05/13/2024 12:35pm. Just prior to/at the time of the event R6 appears to have been sitting in the dining room awaiting lunch. R6's account of the event is (R6) states other (R9) just came up and started swinging at him; verbal altercation escalated into a physical altercation. Facility staff actions/interventions and response at time of the event includes residents separated immediately, assessment completed.</p> <p>On 5/22/24 at 9:50am, V1 Administrator stated that investigation interviews with the staff were not done and there were no witness statements for the 5/13/24 resident to resident altercation that occurred between R6 and R9.</p>