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	10/05/2024

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 33970 Based on record review and interview the facility failed to prevent the physical abuse of one of three residents (R3)reviewed for abuse in the sample of eight. Findings Include: The Facility's Abuse, Prevention and Prohibition Policy dated 01/24 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 policy documents Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also include the deprivation of an individual, including a caretaker of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause harm pain or mental anguish. It includes, verbal abuse, sexual abuse, physical abuse and mental abuse including abuse facilitated or enable using technology. The Facility's Abuse Investigation dated 9/24/24 documents The investigation shows that (R3) states that (R7) was messing with the diet cards of the residents. (R3) asked (R7) not to play with the cards so the residents will get the correct meals. (R3) continued to state that some of the cards were on the floor, and she bent down to pick them up and (R7) pulled her hair and pushed her head down. On 10/4/24 both R3 and R7 refused to speak about the incident on 9/24/24. On 10/4/24 at 12:30 PM V1 (Administrator) stated The incident on 9/27/24 between (R3) and (R7) would be considered founded physical abuse because (R7) did in fact pull (R3)'s hair and push her head. We were not able to get a reasoning because (R7) would not speak to us about it, but she (R7) did go out for a psychiatric evaluation and returned to the facility with no further aggressive behaviors.

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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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. 38396 Based on interview and record review the facility failed to not base a residents involuntary discharge on the residents status at the time of transfer to an acute care facility and ensure a signed physician discharge order was in place when serving a notice of involuntary discharge for one of three residents (R1) reviewed for involuntary discharge in the sample of eight. Findings include: The facility's Facility Assessment, dated 8/16/24, documents the facility has an average daily census of 96 residents and the top three diseases and conditions among residents in the facility are Schizophrenia, Bipolar disorder and Schizoaffective disorder. This Facility Assessment also documents Services offered: Mental Health and Behavior. Manage the medical conditions and medication-related issues causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, trauma/PTSD (Post Traumatic Stress Disorder), other psychiatric diagnoses, intellectual or developmental disabilities. R1's Admission Record documents R1's date of admission to the facility was 1/30/24 and her diagnoses on admission included: Bipolar disorder, Generalized Anxiety and Conversion Disorder with Seizures or Convulsions. R1's Preadmission Screening and Resident Review (PASRR), dated 6/4/24, documents R1 Needs continued twenty-four/seven help from nursing facility staff with completing activities of daily living, maintaining safety, getting around, managing mental health symptoms and taking recommended medications in a structured setting. This same screening documents R1 will need to be provided the following services and/or supports: Crisis Intervention Services, Individual, group, and family psychotherapy and Formal Behavior modification programs. R1's Minimum Data Set assessment, dated 8/1/24, documents R1 has Severely Impaired Cognition with a Brief Interview for Mental Status score of five. R1's Care Plan, dated 8/9/24, documents (R1) has a behavior problem related to Bipolar disorder, Generalized anxiety disorder. (R1) has verbal and physical aggression towards staff and peers. Will state she needs to go to the hospital so she can get a turkey sandwich and soda. Interventions dated 2/19 and 2/20/24 on this same care plan document During episodes of agitation, divert (R1's) attention from stimulus. When (R1) becomes agitated/aggressive: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; offer activities. R1's Care Plan, dated 2/19/24, documents (R1) is at risk for elopement related to (R1) exhibits a tendency to seek to leave facility or wander near exits. Related diagnosis/condition- Poor safety awareness with Bipolar disorder, poor impulse control. (R1) has the potential to be verbally aggressive related to poor impulse control. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Progress Notes, dated 2/14/2024 at 2:34 PM, documents (R1) exited A hall door, stated she was walking home. Staff present with resident at all times while outside the facility. PD (Police Department) contacted by staff, resident asking to go to hospital. Ambulance contacted, ambulance took patient via stretcher to (local hospital) for psychiatric evaluation. R1's Progress Notes, dated 2/18/2024 at 6:00 PM, documents (R1) was at the nurses station just used the phone when another resident came up to use the phone. (R1) turned around not knowing another resident was there and bumped into this resident. This upset the other resident and he began yelling at (R1) to watch what she was doing. This resident then called the other resident a b***h and other resident said you're the b***h. The other resident then spit in (R1's) face. Residents were separated immediately. R1's Progress Notes, dated 2/19/2024 at 4:56 PM, documents An incident occurred and was reported this morning where (R1) walked by a resident who was sitting in a chair next to the sunroom, close to the nurses station at which time she called the resident a b***h and spat in his face twice. The other resident got up to grab his walker, spilled his water and then slipped down to his knees. Social Services arrived on the scene just as nursing staff was helping the resident back up and assessing his health and safety. Discussions then took place among social services, administrator, and operations manager. (R1's) POA (Power of Attorney, V13) was contacted and we then had (R1) transported to the hospital and we discussed future plans for the residence upon return to our facility. At this time it was agreed upon that the resident would be better suited to be nearer to the POA, which is her brother, and we are now working on this arrangement moving forward. R1's Progress Notes, dated 2/26/2024 at 12:58 AM, documents (Certified Nursing Assistant) notified this nurse and another nurse of (R1) involved in physical altercation with another resident in the living area. Residents separated and assessed for injury. No injury noted. (R1) sent out by ambulance for psych evaluation at (local hospital). R1's Progress Notes, dated 9/23/2024 at 6:00 PM, documents Late Entry: (R1) was having behaviors through early hours of shift, continuously running out doors, spitting at staff. (R1) stated that she wanted to go home. Successfully got out of the building two times with staff following. Was unable to redirect, came back to the facility with help of police. Called MD (Medical Doctor), got order for (Intramuscular) shot of Haldol (Antipsychotic medication). Once given to resident she attempted to go out door a few more times before settling down and sitting in the dining room for supper. Will continue to monitor for improvement of mood and behavior. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Progress Notes, dated 9/27/2024 at 10:40 AM and completed by V2 (Director of Nursing), documents (R1) ran out of A wing door with 1:1 (one to one staff member) right behind her. This writer was outside and went towards the 1:1 and (R1) to try to help. (R1) was trying to spit on the staff there (another Certified Nursing Assistant and Nurse manager came to help). (R1) continued to spit on staff and hit them as all attempted to calm her down. (R1) stated she was leaving. (R1) threw herself on the ground and refused to get up. Staff assisted resident up into a wheelchair and this writer pushed her wheelchair into the building. Resident attempted to kick the glass door on the way in stating she was going to shatter it. (R1) was rolled in wheelchair into her room. (R1) got up from wheelchair and began to throw everything in her room on the floor. She then tried to kick the screen out of her window in her room. (R1) hit the window with her fists stating she was going to break it. (R1) then went into adjoining room and tried to break the window. She ripped down the blinds in the other room as well. (R1) tried to attack the resident in the adjoining room and staff stood in between. (R1) tried again to spit on the other resident (did not make contact) staff stepped in the middle and (R1) spit on staff. Resident in adjoining room (R4) states she is scared of the other resident now and wants her away from her. 911 called for police assistance and transportation to the hospital. R1's Abuse investigation, dated 9/27/24, documents Staff and (R4) state that (R1) walked into (R4's) room and tore down her blind and broke it. They also stated that (R1) called (R4) a B***h. (R4) and staff deny that (R1) threatened (R4). On 10/4/24 at 11:45 AM, R4 stated I don't want to keep talking about this. I don't know why (R1) came in here and ripped off the blinds. I wasn't scared because there was a bunch of staff with her, she (R1) did not even get close to me or threaten me in any way. She pulled them (window blinds) down threw them on the floor and then left the room. That is it. R1's Notice of Involuntary Transfer or Discharge and Opportunity for Hearing for Nursing Home Residents form, dated 9/27/24 and signed by V1 (Administrator), documents R1 was issued an Emergency Transfer or Discharge due to The safety of individuals in this facility is endangered. This notice does not document a Physician signature or Medical Provider who gave the order. R1's electronic medical record does not document a signed Physician Order for Discharge. On 10/4/24 at 12:48 PM, V8 (Certified Nursing Assistant) stated (R1) was a required one on one care resident who needed constant supervision. It depends on (R1's) mood as far as behaviors. She'd act out and be aggressive, kick or spit when she didn't get her way. I wasn't working the day she was sent out and didn't return but I did hear she was upset over not getting noodles. We do have another resident who has one to one supervision with staff, that's (R8). I have worked on A-hall (R1's former hall) for about six months and (R1's) behaviors were always the same. This aggression and lack of impulse control was not new for (R1). She did take medication for anxiety it helped when she took them. On 10/4/24 at 12:55 PM , V9 (Registered Nurse) stated (R1) was a big elopement risk. She would also spit and be aggressive at times. I worked the day after she transferred out and talked with the other resident (R4). (R4) stated that (R1) broke blinds in her room and called her a b***h. (R4) said she stayed in bed and pretended to be asleep during it but that (R1) did not make contact or threaten her. That wasn't a new behavior for (R1). She has always been combative, verbal, spitting and trying to elope. (R1) was one on one the entire time. We have other residents that have similar behaviors just less frequent. (R1's) behaviors were more frequent and consistent. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/4/24 at 1:17 PM, V2 (Director of Nursing) stated In (R1's) progress notes on 9/27/24, I documented the conversation for Involuntary Discharge (IVD) with (V12, Psychiatrist). I don't have a signed order for the discharge or a communication form from a Physician. I don't know if (V10, R1's Primary Physician) was ever made aware of the IVD. (R1) had a one on one staff member at all times. We do have another resident who has one on one as well, it is (R8). (R8) requires this also due to aggressive behavior. On 10/4/24 at 2:04 PM, V2 (Director of Nursing) stated (R1) wasn't at all acting herself the day she was sent to the ER (emergency room) and issued the IVD. Yes, she's had behaviors since she was admitted here but that day was a new level and way worse. The ER was just going to send her back here after like an hour and a half and we didn't feel she was safe to do so.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. 38396 Based on interview and record review the facility failed to provide medically related social services for one of three residents (R1) reviewed for involuntary discharge in the sample of eight. Findings include: The facility's Facility Assessment, dated 8/16/24, documents the facility has a total of 123 beds and the average of Mental Health/ Behavioral Health Needs in the resident population ranges between 100-123. This Facility Assessment also documents Services offered: Mental Health and Behavior. Manage the medical conditions and medication-related issues causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, trauma/PTSD (Post Traumatic Stress Disorder), other psychiatric diagnoses, intellectual or developmental disabilities. Provide person centered/directed care: Psycho/social/spiritual support: Provide opportunities for social activities/life enrichment (individual, small group, community). This assessment also documents the facility staff will include Social Services, Behavioral and Mental Health Providers. R1's Preadmission Screening and Resident Review (PASRR), dated 6/4/24, documents R1 has diagnoses of Bipolar Disorder, Generalized Anxiety Disorder and Conversion Disorder with Attacks or Seizures. This form also documents R1 Needs continued twenty-four/seven help from nursing facility staff with completing activities of daily living, maintaining safety, getting around, managing mental health symptoms and taking recommended medications in a structured setting. This same screening documents R1 will need to be provided the following services and/or supports: Crisis Intervention Services, Formal Behavior modification programs, Individual, Group, and Family Psychotherapy: Explanation- Counseling from nursing staff could help when you do not feel well. Group Therapy led by a social worker will allow you to be around others who share similar experiences as you. One on one meetings with a Psychologist, Therapist, or Social Worker can help you talk about and understand why you hear or see things others cannot hear or see, have false beliefs, think others are out to get you, or feel depressed and and will help you find ways to cope with your symptoms. R1's Care Plan, dated 8/9/24, documents (R1) has a behavior problem related to Bipolar disorder, Generalized anxiety disorder. (R1) has verbal and physical aggression towards staff and peers. Will state she needs to go to the hospital so she can get a turkey sandwich and soda. Interventions dated 2/19 and 2/20/24 on this same care plan document During episodes of agitation, divert (R1's) attention from stimulus. When (R1) becomes agitated/aggressive: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; offer activities. R1's Care Plan, dated 2/19/24, documents (R1) is at risk for elopement related to (R1) exhibits a tendency to seek to leave facility or wander near exits. Related diagnosis/condition- Poor safety awareness with Bipolar disorder, poor impulse control. (R1) has the potential to be verbally aggressive related to poor impulse control. R1's Care Plan, dated 7/14/24, documents (R1) may display ineffective coping or overt behaviors due to PTSD. Known triggers include; Not being able to see her kids and her brother. Known psychosocial issues/behaviors attributed to PTSD: Elopement. Interventions: Encourage and assist (R1) to identify factors that contribute to well-being given current ability and resources. Assist to fulfill within facility resources. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Nursing Progress notes dated 2/2024- 9/2024 document numerous episodes of behaviors exhibited by R1 including verbal and physical aggression, spiting and swearing towards facility staff and other residents in the facility. R1's progress notes also document numerous episodes of R1 exiting the building or searching for ways to exit. R1's Social Services notes, dated 6/13/24-9/27/24, do not document R1 was offered any Social Service one on one visits, group therapies, psychosocial therapies related to R1's medical conditions, or any behavioral management interventions from the social service department. The Social Service notes for this time frame only document multiple referrals seeking placement for R1 in other facilities. On 10/4/24 at 12:55 PM, V9 (Registered Nurse) stated regarding the incident that led to R1 being discharged from the facility That wasn't a new behavior for (R1). She has always been combative, verbal, spitting and trying to elope. She was one on one care the entire time. We have other residents that have similar behaviors just less frequent. (R1's) behaviors were more frequent and consistent. I am not aware of (R1) attending any mental or psychosocial/behavioral therapy. On 10/4/24 at 1:05 PM, V6 (Social Service Assistant) stated he has only worked in the facility for two weeks. V6 stated The Social Services Director (SSD V3) has not worked here for very long either, maybe a month or two, and she is sick today. We do not have any in house psych services that I am aware of. We don't have any groups or behavioral therapies at this times for social services. We are a new department and are working to get group therapies implemented. V6 denied ever dealing with R1 prior to her discharge. On 10/4/24 at 2:04 PM, V2 (Director of Nursing) confirmed the facility does not have in house psychiatric therapy or in person psychiatrist visits. V2 stated The psychiatrist visit are conducted through telehealth. On 10/5/24 at 4:15 PM, V1 (Administrator) confirmed R1 did not have any psychosocial therapies taking place in the facility during her stay. V1 stated Our SSD (V3) has been in the facility maybe three to four weeks. We have a brand new social services team. I can't be sure how long we were without someone in the SSD role but during that time other employees, including (V2) were covering those social service duties.