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	02/23/2023

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 23028 Based on record review and interview, the facility failed to notify the family/physician of a change in resident's medical condition and/or transfer to the hospital, for four of four residents (R6, R1, R5, R20) reviewed for change in condition, in a sample of 25. Findings include: The facility policy, titled Notification for Change in Resident Condition or Status (revised 12/07/17), documents The facility and/or facility staff shall promptly notify appropriate individuals (i.e., Administrator, Director of Nursing, Physician, Guardian, Healthcare Power of Attorney, etc.) of changes in the resident's medical/mental condition or status. Responsibility: Administrator, Director of Nursing, Charge Nurse. 1. On 1/24/23 at 2:48 pm, V1 (Administrator in Training/AIT) stated the day prior (1/23/2023) R6 exited the facility in the presence of V2 (Administrative Assistant in Training), who immediately walked out with R6 and was following her. V1 stated herself and V3 (Resident Care Coordinator) and V7 (Registered Nurse/RN) also went outside to follow R6 and try to redirect her back to the building. V1 stated R6 walked about four blocks as they followed, and then ran into a field, taking off all her clothes, grabbing loose grocery bags that were laying on the ground and began threatening to hang herself with them. V1 stated R6 then ran to the cemetery. V1 indicated they could not get R6 to comply with putting on her clothes and returning to the facility, so they called for an ambulance to transport her to the local hospital. V1 stated V3 did not notify R6's State Guardian (V30), who is also R6's mother, of R6 leaving the building and threatening suicide or that R6 had been taken to the hospital. V1 stated staff should have notified V30 and the physician at the time R6 was sent out by ambulance of what had occurred and where R6 was being transferred to. On 1/25/23 at 12:07 pm, V30 stated she was unaware R6 had been transferred out of the facility on 1/23/23 until the hospital R6 was transferred to called her the day after (1/24/23). V30 stated R6 is at a hospital that is approximately 200 miles from the facility, and she knew nothing of R6's threats of suicide or that she left the facility. V30 stated, This happens all the time. (R6) had three prior hospitalization s this year that the facility did not notify me of, and (R6) has been sent out to the emergency room numerous times in the last few months that I was completely unaware of. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/24/23, R6's medical record, including Nursing Progress Notes and Physician's Orders, contained no documented evidence that R6 left the facility and threatened suicide on 1/23/24, or that R6 was transferred to the hospital by ambulance. R6's medical record contained no documented evidence of R6's physician being notified of her change in condition and transfer. Nursing Notes, dated 7/10/22, document Writer received call from (V30) stating (R6 is two hours away in a hospital). (V30) stated she was not contacted by facility about transferring her daughter out of the facility. Administrator notified. 33960 2. R1's Report of Monthly Weights and Vitals, dated 2022, documents the following weight: 11/22, 204 lbs (pounds). R1's Dietary Services Communication, dated 11/18/22, documents, Observation: Gradual weight loss. Dietary Recommendations: 4 oz high calorie high protein shake at lunch. This communication has no documentation that the physician nor V45 (R1's Power of Attorney) was notified of this recommendation. R1's Report of Monthly Weights and Vitals, dated 2022, documents the following weight: 12/22, 199 lbs (pounds) which is a 17 lbs and 7.9% weight loss in three months (9/22, 216 lbs). R1's Dietary Services communication, dated 12/14/22, documents, Observation: 7.8% weight loss in 90 days. Dietary Recommendations: 4 oz high protein high calorie shake twice a day. This communication has no documentation that the physician nor V45 were notified of this recommendation. 3. R5's Dietary Services Communication, dated 10/18/22, documents, Observation: 12.23% weight loss in 180 days. Dietary recommendations: high calorie high protein ice cream cup at lunch. The communication was signed by the physician approving the dietician's recommendation. The form has no documentation of V44 (R5's Power of Attorney) being notified. R5's Quality Care Reporting form, dated 10/27/22 at 12:30 a.m., documents that R5 had a fall in R5's room. The form has no documentation of V44 being notified. R5's Dietary Services Communication, dated 12/14/22, documents, Observation: 7.59% in 30 days, 14.62% in 90 days, 18.44% in 180 days weight loss. Dietary recommendations: Chocolate high protein high calorie ice cream cup at lunch, 4 oz high calorie high protein shake twice a day, weekly weights for four weeks. The communication was signed by the physician approving the dietician's recommendations. The form also documents that this document was noted on 1/6/23, and there is no documentation of V44 being notified. R5's Dietary Services Communication, dated 1/19/23, documents, Observation: 15.15% (weight loss) in 90 days, 20.45% in 180 days weight loss. Dietary recommendations: 4 oz high calorie high protein shake three times a day. The communication was signed by the physician approving the dietician's recommendation. The form has no documentation of V44 being notified. On 1/24/23 at 11:50 a.m., R5 was alert but nonverbal sitting up on the side of her bed. R5 had a purple and yellow bruise with swelling to the outer corner of R5's right eye. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/24/23 at 4:30 p.m., V11 (Registered Nurse) stated, Yeah I guess (R5) does have a bruise on her eye. Supposedly, (V8 Certified Nursing Assistant/CNA) knew for a few days that (R5) had the bruise. I worked the weekend, and she never told me about it. I haven't done any kind of report on it. R5's Nurses' note, dated 12/28/22 at 9:30 a.m., documents, CNAs notified this nurse this morning that R5 was unable to bear weight on her right leg. R5 had to be placed in a wheelchair and placed on 1 on 1's as she was unable to ambulate independently. Also showing nonverbal signs of pain including crying and grimacing. Dr called and updated. He recommended sending R5 out. 911 called and R5 left for hospital via ambulance. On 1/25/23 at 1:25 p.m., V44 stated, They sent her to the ER (emergency room) the day before her MRI (Magnetic Resonance Imaging) because she wouldn't bear weight and she was showing signs of pain. I called the facility because they did not call me to tell me about the MRI being scheduled, and that's when I found out she was at the ER. They said, 'Oh yeah she's at the ER.' I don't trust this facility. They don't notify me of anything. I didn't know she was losing weight until I saw her at the neurologist appointment in November and she looked thinner than I'd ever seen her. 4. R20's Physician's orders, dated 10/22, document that R20 received an order on 10/20/22 for Jevity 1.2 at 150 ml (milliliters)/hr (hour) for 12 hours overnight with a 200 ml water flush three times during feedings and a 30 ml flush twice a day before and after medications. R20's MAR (Medication Administration Record), dated 10/22, documents that R20's order to receive Jevity 1. 2 at 150 ml/hr overnight with 200 ml water flush three times a day during feedings was not started until 10/27/22 (7 days after it was ordered) and there is no documentation of R20 receiving the overnight feeding on 10/29 or 10/30. R20's MAR, dated 11/22, documents that R20 was to receive Jevity 1.2 for twelve hours overnight at a rate of 150 ml/hr being turned on at 8:00 p.m. and turned off at 8:00 a.m. The MAR has no documentation of R20 being administered the feeding on 11/3, 11/5, 11/6, and 11/9 as well as 11/1, 11/2, 11/7, 11/8 were circled as R20's tube feeding was not administered. R20's current medical record has no documentation of R20's physician being notified that the facility was unable to provide R20's tube feeding as well as R20 not receiving any tube feedings. On 2/7/23 at 4:10 p.m., V41 (Medical Director) stated, I should have been notified when the facility wasn't able to get the tube feeding supplies and (R20) went without tube feedings before 11/9/22. On 2/1/23 at 2:25 p.m., V28 (Dietary Manager) stated, The nurses should notify the doctor and families of significant weight loss. On 2/8/23 at 1:50 p.m., V3 (Resident Care Coordinator/Acting Director of Nursing) stated, The nurses should be notifying the family of all medication changes, falls, injuries, changes of condition, and weight loss. The physician should be notified by the nurses immediately of weight loss. V3 also stated, If they don't sign it off, we don't know if it was done. The rule of thumb is if no signature then it wasn't done.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 23028 Based on observation, interview and record review, the facility failed to provide a clean, comfortable, and homelike environment for their residents. These failures have the potential to affect all 116 residents that currently live in the facility. Findings include: Resident Council Meeting Minutes dated 1/10/2023 by V16 (Activities Director), document resident concerns with adequate heat in some resident rooms, mice throughout the facility, mouse droppings in drawers in resident rooms and on the floors, lack of hot water, and feces being left in the showers and other areas of the facility. A Resident Council Issues Form, dated 1/10/23, documents Department: Maintenance. Concern/Complaint: No showers for a week while renovations are going on. No electricity in B-Hall is still happening. Residents are upset that they went 6 days without hot water. They would also like to know why they have to turn the hot water on in the sink for the hot water in the shower to work. Heating issues are still happening. Repairs need to be done to code. Mouse droppings in drawers, spiders and ants in building. Another Resident Council Issues Form, dated 1/10/23, documents Department: Housekeeping. Concern/Complaint: Residents would like more (housekeeping) staff. Feces are spread through the facility. When it happens, the floor needs to be sanitized right away. Sanitation tools still need to be provided for CNAs (Certified Nursing Assistants). Mouse droppings in drawers. A Resident Council Meeting Summary, dated 1/10/23 by V10 (Ombudsman) documents, Residents would like housekeeping to stay later as the aids do not have the things they need for cleaning up messes. Residents are finding (feces) on their toilets and sinks in their bathrooms and shower rooms. A resident stepped in (feces) and walked all through the facility tracking it everywhere and it was not cleaned up until housekeeping came back in. Residents reported their heat is not working in their rooms. I have talked to (V1/Administrator in Training) about this and every time it is bought up, (V1) states she has to follow up with (Maintenance). V10's documentation also includes, Mouse droppings all over facility. On 01/26/2023 at 11:10 am, V10 provided a copy of documented concerns that R2 handed out to everyone in attendance at the 1/10/23 Resident Council Meeting. R2 documented the following, We have very good housekeepers now. But they leave at 5:00 (p.m.) or so. This facility doesn't shut down at 5:00 pm. There needs to be a housekeeper to sanitize bodily secretions off of the floors and other issues. Yes, some things can be accomplished by CNAs (Certified Nursing Assistants), but this administration does not supply the CNAs with any tools and sanitation equipment to properly do it. We share bathrooms with 3 other people. Some residents have to be cleaned. The basins get used for this but never get sanitized, and We have gone extended periods of time without hot water. We have gone extended periods of time without electricity and lights in our bathrooms. Enough is enough. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 1/26/23 at 8:15 am, V10 (Ombudsman) stated she was present at the 1/10/23 Resident Council Meeting, along with several residents, V1 (Administrator) and V2 (Assistant Administrator in Training). V10 stated R2 (Resident Council [NAME] President) was voicing most of the concerns, as he had documented them and passed his concerns out to everyone at the meeting. V10 stated all the other residents present were agreeing with R2's concerns. V10 stated multiple residents had complaints about the heat not working in some resident rooms, mice in the facility, feces on the floor for extended periods of time, and resident drawers have mice droppings in them. V10 stated these concerns have been ongoing, and this is not the first time they have been brought to the attention of V1. V10 stated when she visits the facility, it is overall dirty, especially the floors. On 1/24/23 at 10:33 am, the floor of R3's room had noticeable buildup of dirt and grime in several locations. At that time, R3 stated, The two younger housekeepers are not sweeping or mopping his floor, but the two older housekeepers keep my floor clean when they are here. R3 stated he caught a mouse in his room the day prior, and then opened the bedside dresser drawer to show the mouse droppings in it. R3 stated he does not keep food in his room because of the mice problem throughout the facility. There were no mouse traps in R3's room on 1/24/23. On 1/24/23, at 2:00 pm, R4 was interviewed regarding mice in the facility and the cleanliness of her room. R4 stated, Oh, the mice are a real problem. I just had one crawl on my shoulder last night as I was laying in bed. You should look in those drawers. At that time, mouse droppings were observed in the top drawer of her dresser and in the bottom drawer of her nightstand. There was dirt and grime build up on the floor, along with pieces of trash. At 2:12 pm, while interviewing R4, a mouse ran across the floor and under R4's bed. R4 stated, See, there they (the mice) are! R4's roommate (R22) spoke up and stated, The staff just tell us this is an old building, and we need to just get used to the mice. They don't realize that they need to clean, too. R4 and R22's bathroom had feces on the toilet seat and mouse droppings on the floor under the sink. On 1/24/23 at 11:50 a.m., R5's room had mouse droppings scattered along the baseboards and behind the toilet. On 1/24/23, at 10:28 am, an attempt was made to interview R17 in his room, but he was not there. Upon entering R17's room, it was noticeably very cold, but it was assumed at that time R17 may have wanted his room cold. On 1/31/23 at 12:59 pm, R17 was in his room wearing a heavy jacket. The temperature in R17's room was very cold. R17 stated, It's so cold in here. I've told them that my heater stopped working one week ago and I was told they are waiting on a part to fix it. R17 stated, I have a mouse that lives under my nightstand. R17 opened the door to his nightstand, and it contained numerous mouse droppings. There were no mouse traps seen in R17's room. On 1/25/23 at 10:15 a.m., V22 (Housekeeper) stated, We have issues with mice. I haven't actually seen them, but I see where they are chewing on things like resident food. I see the droppings in drawers as well. The residents will say they see them running across the floor. On 2/1/23 at 1:15 p.m., R14 stated, We have mice. I've seen them go across the floor before. See there's mouse poop in my closet (pointing at closet). Mouse droppings were on the floor in her closet. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 1/24/23 at 3:45 p.m., V16 (Activities Director) stated residents continue to complain about the mice and there are mouse droppings in the vending cart. V16 stated, There are mice droppings everywhere, and I found a bag of pretzels with a hole chewed through it in a resident's bedside table. V16 stated recently a resident had a box of snacks that he kept in the Activity Room and mouse had gotten into the box eating a whole container of noodles. On 1/25/23 at 12:59 pm, V1 (Administrator in Training) was interviewed regarding the concerns brought forth in the 1/10/23 Resident Council Meeting. V1 stated she was present for that meeting and was aware that residents had numerous complaints. V1 stated the facility has tripled their pest treatments in the facility, and pest control now comes weekly. V1 stated the Regional Maintenance Supervisor has gone room to room to identify mouse holes in the walls and get them patched, but it is not 100% done. V1 stated Corporate Office was asked to hire more housekeeping staff to keep up with cleaning, as well. V1 was aware of electrical and hot water issues but did not know the status of those concerns. V1 indicated she has told housekeeping and the Certified Nursing Assistants to look through drawers and clean and sanitize if mouse droppings are found but is unaware if this is being done on a scheduled basis. On 2/06/23 at 2:09 pm, V37 (Maintenance Director) stated R17's heater in his room has been nonfunctioning for over a week now. V37 was advised that R17 stated on 1/31/23 the heater had been broken for a week and V37 confirmed that was true. V37 stated the part to repair R17's heater was not approved by Management to be ordered until 2/02/23. V37 stated he is not sure what date it was ordered after the approval, but stated they are awaiting the delivery of the parts. V37 stated other residents have had issues with the heaters in their rooms, but he repaired them. The CMS-672 (Resident Census and Conditions of Residents), dated 1/24/23 and signed by V1 (Administrator in Training), documents 116 residents currently live in the facility.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 23028 Based on interview and record review, the facility failed to make a prompt effort to resolve numerous resident grievances filed with Social Services and voiced during the Resident Council Meeting (1/10/23). This failure has the potential to affect all 116 residents that reside in the facility. Findings include: The facility policy, titled Resident Grievances/Complaints (no date), documents It is the policy of (the facility) to actively encourage residents and their representatives to voice grievances and complaints on behalf of themselves or others without discrimination or reprisal. Grievances and/or complaints may be reported to the Administrator, any staff member, the Resident Advisory Council, the Long-Term Care Advisory Board and to State Agencies. All staff is required to report any and all grievances and complaints received from Residents. The Administrator is responsible to promptly resolve complaints and grievances. Procedures for filing and handling grievances and complaints are: 1. Complaints and grievances may be presented to any staff member at any time. If possible, the staff person will resolve the problem immediately. 2. Resident Council meetings are to allow time for Residents to address complaints, grievances and other concerns which shall be reflected in minutes of the meeting. The facility liaison to the Resident Council shall direct complaints and grievances to the appropriate Department Head who will resolve the complaints and/or grievances. The Administrator shall also receive copies of the minutes so he/she can follow up to ensure resolution. 3. When a Resident [NAME] or complains to a staff member, that staff member shall explain the issue to his/her Supervisor and together they shall complete a Grievance/Complaint Form. The Supervisor shall then investigate and resolve the complaint. In some cases, it may be necessary for the Administrator to resolve the problem. 4. If it is determined that multi-disciplinary intervention is necessary, the grievance/complaint shall be presented at a regularly scheduled resident care plan conference or at a family conference. 5. Grievance and complaint investigations shall be completed within 15 days by the Investigator who shall distribute copies of the report to the Administrator and the Social Services Director. The Social Service Director shall keep complete forms on file. 6. The Investigator shall notify the Resident and document the results of the investigation and notification on the grievance/complaint form. The Social Service Director is responsible to notify the family and resident representative of the resolution. 7. The Social Service Director and the Administrator shall discuss the grievance or complaint with all persons involved. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The 1/10/23 Resident Council Meeting minutes document the following concerns: Under Administration - lack of communication, V1 (Administrator in Training/AIT) has no training in Behavioral Health, requesting R9 be transferred out of the facility, retaliation by the staff towards residents, HIPPA (The Health Insurance Portability and Accountability Act) violations, staff need a chain of command. Under Nursing - insubordinate staff, medication passes being missed (at 4:00 pm specifically), (staff) ignoring residents, concerns with V3 (Licensed Practical Nurse/LPN) specifically, residents being given the wrong medication, V3 yelling at family members, V27 (LPN) is administering multiple medication passes at once and sleeps in the Nursing Office, LPN's (Licensed Practical Nurses) are stealing narcotics, Nurses retaliating when residents give them issues, and Diabetic (residents) need to be monitored. Under CNAs (Certified Nursing Assistants) - Yelling at residents is not ok and needs to stop and retaliating with residents when they have issues with things. Under Side Notes - R9 needs to be a 1:1 (supervision) at all times, over nights too. Residents are not comfortable in (R9's) presence and are scared of him, R9 is very violent, overly sexual, calling names, and going through other resident rooms. A Resident Council Concern/Complaint form given to Administration, dated 1/10/23 documents, Some residents feel like there is a lack of communication. Residents would also like if (R9) was (transferred) out of the facility because they feel unsafe, and Residents also think that staff, such as CNAs and Nurses, are retaliating when they bring up issues to them that staff does not agree with. A resident brought up the staff need a chain of command and (V27/LPN) is giving multiple (medication) passes at once. She takes naps in the nursing office. (V27) argues with other nurses. (R2) brought up LPNs stealing narcotics. The Response/Resolution part of this grievance is blank and has not been addressed by Administration as of 1/25/23. A Resident Council Concern/Complaint form dated 1/10/23 given to Department: Nursing, documents Residents feel the department is chaos. There are (medication) passes being missed. 4:00 pm pass especially. Nurses are ignoring residents. The residents would like a D Hall nurse established. Residents are being given the wrong medications. Certain nurses are retaliating against residents that give them issues. Our Diabetic residents need to be monitored more frequently when it comes to their blood sugar levels. They would also like the nurses to go over their medications with them. Residents feel that the nurses could work on their bedside manners. The Response/Resolution part of this grievance is blank and has not been addressed by Administration as of 1/25/23. A Resident Council Concern/Complaint form dated 1/10/23 given to Department: CNAs, documents Residents believe that the CNAs yelling at residents is not okay. Showers need to be cleaned and sanitized after each shower. They are also concerned that the CNAs are retaliating when the residents bring up issues to them that they do not agree with. CNAs need to be marking resident's belongings when they arrive, it's causing issues in other Departments. The Response/Resolution part of this grievance is blank and has not been addressed by Administration as of 1/25/23. A Resident Council Concern/Complaint form dated 1/10/23 given to Department: Dietary, documents Nutrition is horrible. Residents are leaving the tables hungry. Portions are too small. Food is not good. They want knives. Ham and beans are not good, they feel like it's just ham, beans and water. Kitchen is running out of food by the time the second (dining) is ready. (V28/Dietary Manager) is hard to talk to and approach. The Response/Resolution part of this grievance documents, Will try to do better, and is signed by V28. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A Grievance/Complaint form, dated 1/05/23, by R23 documents, (R23) walked in the activity room with money and asked if he could get a soda. (V46/Activities) said yes, so (R23) went to get one off of the shelf and she yelled at him, saying 'NO! You guys need to stop getting stuff off the f*****g shelf.' (R23) replied 'O.K. ' and walked out of (the) activity room. This Grievance was documented as being received by V15 (Social Services), with nothing documented by V1 under the Method of Correction or Disposition of Complaint. A Grievance/Complaint form, dated 1/02/23, by R22 documents, I was told by (V46/Activities) that I could not smoke because (V16/Activities Director) found two vapes in my room. She said it loudly in front of the other residents to embarrass me in front of people. I didn't want people to know I got in trouble. (R22) also stated (V46) will not look them in the eye or treat them with respect. (V46) will refuse to fill up their ice container. This Grievance was documented as being received by V4 (Social Services), with nothing documented by V1 under the Method of Correction or Disposition of Complaint. A Grievance/Complaint form, dated 1/07/23, by R16 documents, The D Hall Nurse did not arrive on time for morning (medication) pass. Resident was very upset and in pain. Writer spoke to B Hall Nurse and was told they were aware, and someone was on their way. Nurse said medication had been pre-prepped by the D Hall Nurse and she could not dispense it. Informed (R16) her nurse was running behind, but she was going to be here soon. (R16) went back to room, visible anger present with no comment. This Grievance was documented as being received by V4 (Social Services), with nothing documented by V1 under the Method of Correction or Disposition of Complaint A Grievance/Complaint Report, dated 1/05/23, documents R6 had concerns with (R9) rubbing on her butt, putting arm around her (and) saying 'Baby, give me a kiss,' touched her breast, looked up her dress. Also, going up (and) down A Hall (at) night, (R6) claimed, 'I can hear (R9) through the wall.' This Grievance was documented as being received by V4 (Social Services), with nothing documented by V1 under the Method of Correction or Disposition of Complaint. (continued on next page)

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	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 1/24/23 at 3:45 pm, V16 (Activities Director) stated, when interviewed regarding the facility's resident grievance process, I have a paper that I made that has the concern on it. I write the concerns out and deliver them to the (specific) Department. The Department is supposed to respond back with a follow up that I then relay back to the resident council the following month. (During the 1/10/23 Resident Council Meeting) Retaliation was (mentioned by R2), but he didn't expand on it. (Medication) passes are (being) doubled up. This was from (R2), but this isn't the first time I've heard it. They mentioned (V27/Licensed Practical Nurse). They will point out (to V27) that it's the wrong pill and will tell (V27 but she) forces them to take it without explaining. This is the first time I've heard this. (R2) said (nurse) popped the narcotic pill out, put it to the side of the medication cart, then slide it into her pocket. V16 stated residents also complained, The diabetics don't get things to help with the blood sugars and it's brushed under the table. (R2) has brought it up, but I've seen it myself. The resident was (R4). (R4) gets pale and real shaky, voice wavering. The nurse was with (R4) but didn't do anything. Residents continue to complain about the mice. There are mice droppings everywhere, and I found a bag of pretzels with a hole chewed thru it in a resident's bedside table. (R9) had a box of snacks in the activity room. A mouse had gotten into a box of noodles and ate the whole container. Mouse droppings (are) in (the) vending cart. The vending cart has snacks they can buy. (R2) reported that if you don't do something the CNAs like, they will raise their voices. And (R9), he's very sexual. (R9) will literally come up behind a person, grab their hips, get real close and dance with them. Multiple residents have brought it up. (R9) is overly sexual. (R9) will make sexual comments to people as well. (Residents) piped in and said (R9) had been overly sexual towards them. They didn't bring up specific times but chimed in when it was brought up. (Complained that R9) would literally walk into a room and take stuff or go through drawers. I don't know if he was in rooms with residents who couldn't tell him to get out, but I wouldn't put it past him. I started in August, but within the last 3 months it's gotten more frequent. (R9) was taken off and put back on 1:1 multiple times for a total of 1 month. (V1/Administrator in Training) was at the Resident Council meeting. (V1) was invited by the residents. I've brought (R9) up to (V1) several times, but he still does things. V16 then confirmed that a copy of the Resident Council meeting minutes for January 2023 was given to V1 for further review. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 1/25/23 at 12:59 pm, V1 (Administrator in Training) confirmed that she was present for the 1/10/23 Resident Council Meeting and she had received a copy of the Resident Council Meeting notes. With regard to the resident concerns brought forth at the meeting, V1 stated, I still want to go through and talk to residents; when I get complaints, I don't always jump. V1 stated, My approach to the wrong medications being given and narcs (narcotics) being stolen was to wait and see how med (medication) pass was going. My thought process is it's not over. I'm waiting to sneak up and see what I catch. V1 stated she did complete a Narcotic Count at the medication carts, which was fine. V1 stated she at some point asked V3 (Licensed Practical Nurse/Resident Care Coordinator) if anything had anything reported regarding missing narcotics, and the answer was no. V1 stated she just started getting copies of the Resident Council Meeting minutes and she received the copy from the (1/10/23) meeting minutes last week. V1 stated she did read the minutes when she received them and acknowledged There were several serious concerns brought up at the meeting. V1 stated she did not interview any residents that had specific concerns, but she did have a conversation with R6 regarding R9. V1 stated she could not recall any specifics regarding the allegation of CNAs yelling at residents, but I decided to do a broad in-service regarding bedside manner and customer service that day, as it was a scheduled in-service day. V1 did admit that the allegations that came from the Resident Council Meeting could lead to an abusive situation. V1 stated, I didn't view the complaints warranted interviewing specific residents in private to determine what CNAs are yelling at residents and what they are yelling at them for. V1 stated she did not interview any staff regarding other staff's behavior. When V1 was questioned about the statement made by R2 that staff are retaliating against them when they complain, V1 stated she talked to my Department Heads and instructed them to do 'Angel Rounds,' inquiring as to if residents have concerns about retaliation. V1 was unable to provide any documentation related to the information gathered during 'Angle Rounds.' V1 stated she did not recall the word retaliation being used in the Resident Council Meeting but concluded retaliation is concerning. V1 denied knowledge of the other individual grievances filed by R23, R22, R16 and R6. The CMS-672 (Resident Census and Conditions of Residents), dated 1/24/23 and signed by V1 (Administrator in Training), documents 116 residents currently live in the facility.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 23028 Based on observation, interview and record review, the facility failed to ensure residents (R6, R10, R11, R18) were free from sexual and verbal abuse by R9, who had known history of sexually inappropriate behaviors towards females, for five of 12 residents reviewed for abuse in a sample of 25. These failures resulted in R6 being groped in a sexual manner and verbally abused, experiencing psychological distress. This facility was previously cited for sexual abuse on 1/09/22 for R9 groping R6's breast. Additionally, the facility failed to prevent known, ongoing sexual relations between R9 and R6, who is Intellectually Disabled, unable to consent, and has a State Appointed Guardian. These failures resulted in an Immediate Jeopardy. While the immediacy was removed on 02/03/2023, the facility remains out of compliance at a Level 2 as the facility continues to conduct ongoing Abuse Prevention Training with all current staff and newly hired staff and the Quality Improvement Program conducts random audits to ensure facility staff's compliance with the Abuse Prevention Program, with an emphasis on Abuse Reporting, Investigation of Abuse Allegations, and staff's understanding of Abuse Prevention Training. Findings include: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The Facility policy, titled Abuse Prevention Program (revised 11/28/2016) documents, This facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, and exploitations defined below. This includes, but is not limited to, freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This facility therefore prohibits mistreatment, exploitation, neglect, or abuse of its residents, and has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent the occurrences of mistreatment, exploitation, neglect, or abuse of our residents. This will be done by: Conducting required pre-employment screening of employees; Orienting and training employees on how to deal with stress and difficult situations, and how to recognize and report occurrences of mistreatment, exploitation, neglect and abuse immediately to supervisory personal; Training on activities that constitute abuse, neglect, exploitation and misappropriation of resident property; Establishing an environment that promotes resident sensitivity, resident security and prevention of mistreatment, exploitation, neglect and abuse of residents and misappropriation of resident property; including, prohibiting staff from using any type of equipment to keep, distribute photographs and recording of residents that are demeaning or humiliating; Identifying occurrences and patterns of potential mistreatment, exploitation, neglect and abuse of residents and misappropriation of resident property; Dementia management and resident abuse prevention; Immediately protecting resident involved in identified reports of possible abuse; Implementing systems to investigate all reports and allegation of mistreatment, exploitation, neglect, abuse or residents and misappropriation of resident property; promptly and aggressively, and making the necessary changes to prevent future occurrences; and Procedures for reporting of potential incidents of abuse, neglect, exploitation or the misappropriation of resident property. This facility is committed to protecting our residents from abuse by anyone, including, but not limited to, facility staff, other residents, consultants, volunteers, and staff from other agencies providing services to the individual, family members or legal guardians, friends or any other individuals. The Abuse Prevention Program documents Sexual Abuse is non-consensual sexual contact of any type with a resident. Verbal abuse is the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or families, or within their hearing distance regardless of their mental ability to comprehend or disability. 1. R9's Pre-Admission Screening System, dated 11/18/21, from prior to R9's admission (11/24/21) to the facility and obtained from R9's medical records at the facility, documents, Behavior Assessment Summary: (R9) is a [AGE] year-old male who was admitted to hospital due to being actively psychotic. (R9) has a history of hospitalization s and being aggressive. Behavior type: Antisocial behavior; Criminal justice system involvement; Fire setting or arson; Physical assault/injury threatening to others; Poor judgement placing self or others at risk; Property damage; Self injurious behaviors; Serious wandering, elopement; Sexual aggression. A Cumulative Diagnosis Log (no date) documents R9 has the current diagnoses of Schizoaffective Disorder, Bipolar Type and Hypersexuality. A Minimum Data Set assessment, dated 11/30/22, documents R9 can ambulate independently. A Final Incident Report to State Agency, dated 1/14/22, summarized that R9 had grabbed R6's breast as she was near the ice machine in the kitchen area, and R6's account of what had occurred was substantiated by resident interviews that had witnessed the incident. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R9's current Plan of Care documents (beginning 3/15/22) (R9) has behaviors that others may find disruptive/socially inappropriate. Others may seek reprisal against the resident. Behavior exhibited sexually inappropriate, yelling out, verbal outbursts, and instructs staff 1 on 1 (at) all times when out of room and council on appropriate interactions (with) peers (and) staff as needed per his behaviors. The Care Plan also documents, R9 has displayed verbal aggression, inappropriate touching, wanders, irregular thoughts. A Psychosocial Assessment, dated 11/30/22 identifies R9 has behaviors of being socially inappropriate, wandering, seducing/soliciting, seeking intimate contact, and masturbating. Daily Resident Monitoring documents R9 was decreased from 1 on 1 supervision to Resident Monitoring - 15 minutes - Staff (must) make visual contact with resident every 15 minutes on the following dates: 12/15/22, 12/16/22, 12/17/22, 12/18/22, 12/20/22, 12/21/22, 12/23/22, 12/25/22, 12/26/22, 12/27/22, 12/30/22, 12/28/22, 12/31/22, 1/01/23, 1/02/23, 1/03/23, 1/04/23, and 1/05/23. All of R9's 15 Minute Monitoring reports document his location as being in either the hallway, dining room, resident room, television room or patio. R9's medical record contains no documented rationale for decreasing his level of supervision to every 15-minute checks on those dates. Daily Resident Monitoring logs for the dates of 12/11/22, 12/13/22 and 12/14/22 indicate Resident Monitoring - One to One, however, on those three dates the One to One is crossed out with an ink pen and R9's location is only documented every hour on the hour. On 2/16/23 at 11:37 am, V9 (Unit Aide) clarified the December Resident Monitoring for R9, as her initials are on several of R9's monitoring logs. V9 was given R9's logs from 12/11/22, 12/13/22 and 12/14/22 and asked about the One to One that was crossed out on the top of the log sheet. V9 stated There was, like a week in December when we took (R9) off 1:1 and he was just on every 15-minute checks, so the 'One to One' was crossed out on certain days so people would know he (R9) was not 1:1 on those days, but a every 15-minute check. I'm not sure who made that decision to decrease his supervision. A Grievance/Complaint Report dated 1/05/23 and completed by V4 (Social Services), documents R6 complained (R9) rubbing on her butt, putting arm around her (and) saying 'Baby, give me a kiss,' touched her breast, looked up her dress. Also, going up (and) down A Hall (at) night, (R6) claimed, 'I can hear (R9) through the wall.' Resident Council Meeting minutes dated 1/10/23 document resident complaints that (R9) needs to be on a 1 on 1 at all times, overnights too. Residents are not comfortable in his presence and are scared of him. (R9 is) very violent, overly sexual, calling names, going through resident's rooms, (R10, R6, R11 and R12) have all brought attention to this. A Resident Council Concern/Complaint form, dated 1/10/23 by V16 (Activities Director), documents Residents would also like if (R9) was out of the facility because they feel unsafe. A documented summary of V10's (Ombudsman) notes from the 1/10/23 Resident Council Meeting include the following information: Other concerns: (R9) is touching and grabbing women in a sexual behavior. (R9) is pinning residents against walls and counters as well. (R6) stated that (R9) has looked up her skirt, grabbed her breast, and rubbed his penis on her many times. It was stated in resident council that (R9) does not have a 1:1 anymore, and (R13 stated R9) touched my boobs and rubbed his penis on me, and (R11 stated R9) is getting into people's faces and personal space and touching the way she don't want to be touched. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 1/26/23 at 4:11 pm, R9 was ambulating throughout the building, into the common areas and up and down hallways. R9 was being followed by V28 (Dietary Manager) who was approximately 15 feet or more behind him watching a video on her cell phone as he ambulated throughout the hallways. R9 eventually returned to his room and V28 sat down in chair outside his room. When asked why R9 needed 1:1 supervision, V28 stated for his behaviors. When V28 was asked as to what type of behaviors R9 exhibited, V28 stated she did not know. On 1/24/23 at 3:15 pm, V4 (Social Service) stated R6 told her on 1/05/23 that R9 was rubbing on her butt, breast and saying inappropriate sexual statements to her, wanting a kiss and telling her to drop that a**. According to V4, R6 stated she could hear R9 wandering the halls at night, all night, going into others' rooms. V4 stated R6 was very upset over the fact that R9 had been on 1:1 supervision in the past for similar behavior but was taken off 1:1 supervision and was allowed to do this to her. V4 stated she wrote up the statement from R6 on 1/05/23 and then took it to morning meeting with all the Department Heads on 1/06/23 to be discussed. V4 stated V1 (Administrator in Training) and V2 (Assistant Administrator in Training) were present in that meeting. V4 stated R9 was eventually put back on 1:1 supervision, but not until another incident occurred a week later. V4 was uncertain of the details or nature of that incident. V4 stated she felt what R9 was doing to R6 was sexual abuse, but R9 doesn't have the ability to understand that his behavior is sexually inappropriate. On 1/24/23 at 3:45 pm, V16 (Activities Director) stated she typed the 1/10/23 Resident Council Meeting Minutes and then completed a form with each concern on it and delivered those concerns to the appropriate Department Heads. V16 stated V1 was present at the 1/10/23 Resident Council Meeting, as she was invited by the residents due to all the concerns. V16 stated multiple residents brought up R9's behavior in that meeting, complaining that R9 is very sexual. (R9) will literally come up behind a person, grab their hips, get real close and dance with them. V16 stated residents complained that R9 would make sexual comments to people as well. They piped in and said (R9) had been overly sexual towards them. They didn't bring up specific times but chimed in when it was brought up. V16 stated she started at the facility in August, and in the last 3 months R9's sexual behavior has become more frequent. V16 stated R9 was taken off and put back on 1:1 supervision multiple times in a month and V16 discussed this with V1 several times, as it was concerning to her. V16 stated, I've brought this up to (V1) several times, but (R9) still does things. I really don't know if what he is doing is sexual abuse or not. I really can't say. I never received any kind of abuse training when I started in August or since then. On 1/26/23 at 8:15 am, V10 (Ombudsman) stated she attended the most recent Resident Council Meeting (1/10/23). V10 confirmed that V1 and V2 were present for that meeting. V10 stated during the meeting, R6 and some other female residents complained about R9 being sexually inappropriate. V10 stated R6 verbalized in the Resident Council Meeting R9 rubbed his penis on her and rubbed her boobs. V10 stated she was in the facility on 1/19/23 and R9 was roaming the hallway unsupervised and groped her buttocks. V10 indicated that each time she has been in the facility recently, on 1/03/23, 1/10/23 and 1/19/23, R9 was not on 1:1 supervision and residents have complained to her that R9 isn't supervised enough. V10 stated she spoke with V1 on 1/19/23 about R9's behaviors and lack of supervision, and V1 told her, The facility does not want to have (R9) on 1:1 at all times because it is expensive. V10 stated R6 tries to run away from the facility and recently cut her head when she put it through her bedroom wall. V10 stated she talked with R6 about this behavior and R6 stated she did all those things because staff wouldn't listen to what she had to say or help her. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 2/04/23 at 11:10 am, V32 (Registered Nurse) stated R9 had been on 1:1 supervision for his sexual behaviors, but it stopped because the facility didn't have enough staff to provide constant supervision of him. V32 stated she heard that R6 reported R9 touched her inappropriately on 1/05/23, but nothing was done about it. V32 stated a few days after 1/05/23, R9 went up to R14 and started humping her from behind, rubbing his crotch on her. V32 stated she texted V1 to tell her about the situation, since R6 had just reported something similar on 1/05/23, but V1 just got upset with her for texting her at night. V32 stated she was concerned because she thought R9 was to be supervised 1:1 all the time after the last abuse (Illinois Department of Public Health deficiency) written on him, from what I was told. V32 stated she has even witnessed R9 do sexually inappropriate dancing during Moves and Grooves, which is an activity ran by V16 (Activities Director). V32 stated It was almost like staff were encouraging this behavior from (R9) and didn't understand it was wrong and inappropriate. V32 stated she has witnessed night shift Unit Aides watching movies on their phones when they are to be providing residents, R9 included, with 1:1 supervision. On 2/01/23 at 5:40 pm, V34 (Unit Aide) stated about two months ago, R9 was going up to residents and 'air humping' them, rubbing himself on males and females. It was so bad the police had to be called, but the police said they couldn't do anything with him. V34 stated R9 was being supervised 1:1 that day and still acting out towards other residents sexually, because staff couldn't stop him. V34 stated he has provided R9 with 1:1 supervision before and R9 will not want to stay in his room and will want to walk around the building. He is fast. Some residents get scared of (R9) because he will yell at them. I've been told in the past, from other staff and (R6) that (R9) needs to be watched for doing inappropriate things to her. On 1/25/23 at 10:35 a.m., V19 (Certified Nursing Assistant) stated, (R9) likes pulling his pants down exposing himself and dancing around inappropriately laughing; it's common behavior. He wanders in and out of resident's rooms. On 1/25/22 at 10:50 a.m., V25 (Licensed Practical Nurse) stated, (R9) is like a vampire; sleeps all day then awake at night and starts acting out. He is very animated. He is sexually aggressive verbally. Last night he was sexually inappropriate with me. On 1/26/22 at 10:40 a.m., V14 (Social Service) stated, (R6) complained to me about (R9) because he grabbed her butt. I think this happened in about November. (R6) said she didn't like him talking to her because he touched her butt and things like that. I reported these things to (V4/Social Services Director). On 1/26/22 at 10:50 a.m. V15 (Social Services) stated she was aware of R9's sexual advances, stating for instance he went behind (R14), grabbed her breast and pretended to hump her. It happened over the weekend, and I was told about it the following Monday when I came in, so I didn't report it to anyone. It was either the weekend of 12/31/22 or 1/07/23. V15 then stated, The other thing I'm aware of is (R9) grabbing (R6's) breast. This incident wasn't long before (R14's) incident or maybe the same weekend. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 1/26/22 at 2:10 p.m., V8 (Certified Nursing Assistant) stated R9 will say sexually inappropriate statement to residents. V8 stated, I know he's tried to grab females, like (R6), going up behind her inappropriately. (R6) reported to me that (R9) wouldn't quit following her and tried to grab her. I told her to talk to Social Services, because I know something may have been done previously, but she still complains about it. I didn't report anything to (V1). I would say it was sexual abuse because (R9) is inappropriate with it. (R9) will randomly just get in a mood where he gets sexually inappropriate. I want to say he did have a 1:1, but he is quick (moving). I don't know who determines if he needs a 1:1. He has come off then he will be put back on is because he's been sexual or trying to poop outside. On 1/25/23 at 10:17 am, R10 stated R9 has never done anything sexually or physically inappropriate to her, but she has heard from other residents that he can be physically and sexually aggressive. R10 stated, (R9) will follow me a lot; he doesn't make sexual advances, just grabs his genitals in front of me. R10 stated she has told several staff that I think (R9) is at the point where he wants a woman; he is a young, after all. (R9) asked me to get him a {Name Brand adult men's magazine} magazine recently and that makes me think he is sexually frustrated. On 1/26/23 at 4:21 pm, R3 stated R9 has been on and off 1:1 supervision since he was admitted . R3 stated R9 was most recently returned to 1:1 supervision after the January Resident Council Meeting, when all that stuff was brought up about (R9) being really sexual with the female residents, touching them and rubbing himself against them. But even after that, (R9) will just roam free some nights. He goes in and out of other resident rooms. I think he looks for food, but who knows what all he's doing in there. I've seen (R9) come up behind the girls and be sexual with them, touching them in places he shouldn't, just out in the open and in front of staff. They don't do anything most of the time. Some of the staff will tell him to stop or distract him away from the girls, but (R9) pretty much does what he wants. On 2/01/23 at 12:50 pm, R18 stated, (R9) has grabbed my arm and pulled me in to him, making me sit on his lap. It made me uncomfortable. I didn't like it. Staff were around; it was by the fireplace, but they didn't stop him. I got up on my own after he let me go. This wasn't that long ago, maybe a month. On 1/25/23 at 10:34 am, R11 stated she did complain at the Resident Council Meeting this month about (R9). R11 stated, (R9) will get in my face and yell real loud at me, saying all sorts of mean stuff. R11 stated this had been going on for awhile and staff would see it happening and do nothing. R11 then stated, (R9) has touched me, but I don't want to say where; he scares me. (continued on next page)

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	146097	A. Building B. Wing	02/23/2023

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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 - Immediate jeopardy to resident health or safety Residents Affected - Some	On 1/30/23 at 10:18 am, R6 was interviewed over the phone, as she was admitted to the hospital. R6 stated R9 touches my boobs, tries to kiss me, and will come up to me and rub his penis on me through his clothes. (R9) will hold on to me from behind. It makes me feel uncomfortable and this happens almost every single day. R6 stated R9 will call her names, like N****r, C**t, and B***h when she pushes him away. R6 stated the problems with R9 started over a year ago, and she has told many staff, including V1 (Administrator in Training), V2 (Assistant Administrator in Training) and V4 (Social Services Director). R6 stated, Staff do nothing and (R9) is allowed to come down my hall all of the time. R6 stated sometimes R9 is 1:1 with staff and at other times he's not, especially at night. R6 described how she is afraid to come out of her room, unable to go get ice and eats meals in her room to hide from R9. R6 stated she is afraid of R9 and R9 makes her feel uncomfortable. R6 stated she is coming back to the facility soon and is very worried about what might happen with R9 still in the facility. R6 stated she recently put her head into the wall of her room because she was angry and frustrated with living in the facility. R6 also stated she tried to leave the facility last Sunday, which was why she was in the hospital. When R6 was asked why she tried to leave, she stated she was angry about everything. Having to live there. (R9) not leaving me alone. Staff not listening to me about (R9) and other things. Staff being mean to me. (R9) follows me around all the time calling me names. Staff don't stop him. When R6 was asked if she feels safe in the facility, she stated not at all. R6 stated the last time she tried to run away from the facility she was angry about everything and stated, It was not a good day. I had enough of that place. R6 stated she really wanted to kill herself that day, and just get it over with. R6 stated as she was leaving the building, V6 (Certified Nursing Assistant) was walking behind her and telling her to just go ahead and hang myself. So, that's what I was trying to do, get out of there and kill myself. R6 was interviewed again, after returning to the facility, on 2/01/23 at 12:48 pm. At that time, R6 stated, Just last night (R9) was following me around, he called me a Retarded B***h while staff were with him, following him as he walked around. On 1/31/23 at 1:45 pm, V30 (Police Officer) stated he said he has responded to the facility several times over R6's threats of suicide. V30 stated R6 always tells him that she can't stand to live there anymore because the staff don't listen to her or help her. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 1/25/23 at 12:59 PM, V1 stated R6 came to her with concerns that R9 was getting too close to her. V1 could not recall what day that occurred, but indicated it was recent, within the month. V1 stated, We had actually been trying to wean (R9) off 1:1. V1 stated she had no knowledge of the 1/05/23 grievance completed by V4; however, V1 acknowledged that R9's Resident Monitoring Logs document he was placed back on 1:1 supervision at 12:00 am on 1/06/23. V1 stated she did not know what behavior had occurred for R9 to be returned to a higher level of supervision, nor could she find documentation as to why. V2 was in the office during this interview and denied knowledge of the grievance as well. V1 and V2 denied V4 bringing to the attention of Management that R6 had complaints of R9 touching her sexually during the 1/06/23 morning management meeting. V1 stated, Had I known, I would have reported an allegation of sexual abuse. V1 stated the only thing R6 told her was that (R9) was getting in her personal space, but not that (R9) had physically touched her. V1 stated she did not have any documented evidence of this conversation with R6, or any subsequent actions taken. V1 explained, (R9) is able to be taken off and on 1:1 based on his behavior. They will review his behaviors and if they increase, or if he is not able to be redirected, it can be reimplemented. That's in his Plan of Care. V1 confirmed that she was in attendance for the Resident Council meeting on 1/10/23. V1 stated she did not interview the four female residents that spoke out about R9's behavior. V1 stated, I recall (R6) speaking out against (R9) and (R10) as well. I do not remember the other two residents having specific concerns with (R9). I can't tell you my exact immediate follow up. I did not interview any residents that had concerns. At some point, I had a conversation with (R6 about R9), but I do not know when and did not document the details. 2. An official court document, dated 4/10/2017 documents V30 (R6's Mother) and V37 (R6's Father) as being appointed Guardians of the Estate & Person of (R6), a disabled adult, and are authorized to have, under direction of the Court, the care, management, and investment of the ward's estate and the custody of the ward, and to do all acts required by them by law. A Resident Profile Face Sheet documents R6 was admitted to the facility on [DATE]. A Subpart S Eligibility Screening, dated 5/13/22, documents under Section B that R6 has the diagnoses of Schizo-affective Disorder and Bipolar Disorder, and under Section E - (checked for yes) Are impairments in these areas primarily due to the resident's serious mental illness listed in Section B. (Checked for yes) Resident's impairment cannot be primarily due to any of the following (Check box if impairment is due to diagnosis listed): with Mental Retardation circled. Physician's Orders, dated 1/01/23, document R6 has the current diagnoses of Anxiety, Schizoaffective Disorder, Intellectual Disability, and Chronic Post Traumatic Stress Disorder. R6's Current Plan of Care, which has not been updated since 9/09/22, documents R6 has Impaired Communication (expressive), ambulates independently and has risk factors that require monitoring and intervention to reduce potential for self-injury. A Hospital History and Physical, dated 1/23/23, documents R6 as alert and oriented, but with limited judgement and insight, and below average intelligence. Behavior Tracking for October, November and December 2022 and January 2023 documents R6 is being monitored for the following targeted behaviors: Self Harm/Suicidal Ideations, Repetitive Verbalizations, Physical Aggression Towards Others, Intrusive Thoughts, Verbalized Hallucinations/Delusions, Exit Seeking, Depression, Self-Isolation, and Verbal Aggression Towards Others. Nursing Notes, dated 10/22/22, document (R6) got upset because she was asked to leave boyfriend's room and move down to lobby. She went down D Hall to another resident room. She was redirected to leave the hall because of COVID. (R6) got agitated and walked out of the facility through D Hall. Resident was not easily redirected. Walked down to the graveyard, took off all her clothing and laid naked in (a) field. Stated 'I want to die.' The cops were informed. Effort to get (R6) up not successful. Rescue team informed, got her up and was taken to (hospital). Nursing Notes, dated 12/18/22, document (R6) found in male patient's bed. They were wearing clothes. (R6) said she thought it was ok, as long as they don't have sex. Encouraged (R6) not to go in male resident room. She was easily redirected. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Physician's Orders, dated 2/01/23, document R15 has the current diagnoses of Schizoaffective Disorder, Bipolar type, Catatonic Schizophrenia, and Psychosis. A Surrogate for Decision Making form, dated 12/29/22, documents V36 (R15's Sister) is R15's legal Surrogate Decision Maker. A Social Service Progress Note, dated 12/29/22, documents (R15) has a girlfriend (R6) and family does not want them having sexual relations. R6 and R15's medical record contain no documented evidence of a plan developed or implemented to ensure R6 and R15 were not engaging in sexual activities with each other. On 1/31/23 at 1:05 pm, V10 (Ombudsman) stated V30 (R6's Mother) contacted her today, very upset and concerned about R6 being in a sexual relationship with a male resident in the facility. V10 stated V30 discussed this with the Social Services Department in December, but the facility was not doing anything to stop R6 from having sexual intercourse with this resident. V30 stated the concern is that R6 does not have the mental capacity to consent to a sexual relationship with someone. On 1/31/23 at 2:44 pm, V30 stated V30 found out this summer that R6 was in a relationship with R15. V30 stated she was concerned, because R15 is twice R6's age, but she was just calling R15 her boyfriend. V30 stated nursing staff in the facility started telling her she should press her daughter for more information about her relationship with R15. V30 stated it was as if the staff knew R6 needed to tell her what was really going on with her and R15. V30 stated, Around the beginning of November, (R6) told me she had been caught having sex with this man (R15), in his room and her room, multiple times, and I'm concerned because I'm (R6's) State appointed guardian and (R6) has the mental capacity of a 10-[AGE] year old. I spoke to (V1) immediately after I found out, and (V1) told me (R6) was a consenting adult and there was nothing they could do about her having sex with this man, who is twice her age. On 2/02/23 at 1:30 pm, V30 stated she reviewed her phone records and she spoke with V1 on 11/08/22 about R6 and R15 having sex. V30 stated V1 told her R6's BIMS (Brief Interview for Mental Status) was too high, and they were able to consent to a sexual relationship. V30 stated she told V1 that she did not agree, as (R6) has the mentality of a teenage girl. V30 went on to say, This is my baby (R6) and I feel like (R15) is a predator. On 2/01/23 at 12:52 pm, R15 stated he is in a sexual relationship with R6. R15 stated they have sex in his room or hers, or sometimes on the couch. R15 stated they had been having sex for a while now. On 2/01/23 at 1:17 pm, R6 stated she has sex with R15. R6 stated, (R15) is my boyfriend and we are going to get married. R6 was asked where she has sex with R15, and she stated, Wherever and Oh we've been caught by people. R6 was asked if she had sex with R15 in his room or hers, and she stated both. R6 was asked what happens when they get caught and R6 stated, They just tell us not to do it again. My Mom knows. I told her. I told her we want to get married. On 1/31/23 at 12:59 pm, R3 stated, (R6 and R15) are in a sexual relationship. Everyone knows, including staff. They will lay on the couch in the common area on the other side of the fireplace, where no one can see them if they walk through, make out and fondle each other. They are smart and try to hide it. Staff will let them sit real close on the couch during a movie and say 'Now don't touch each other,' but it doesn't work. This has gone on since I've lived here. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 2/02/23 at 1:59 pm, V4 (Social Services) stated she talked to both R6 and R15's families regarding their sexual relationship in December, but (R6 and R15) had a high enough BIMS, so they could not stop them. V4 stated, (V1) was fully aware (of their sexual relationship); she has talked to (R6 and R15's) family regarding this. V4 stated they did discuss developing a care plan with individualized interventions to keep R6 and R15 from having sexual relations, but that never transpired. V4 stated R6 openly talked about being sexual with R15. V4 stated, It was common knowledge amongst staff, that they would have sex; it would trickle down to residents and then to Social Services. On 2/01/23 at 2:33 pm, V14 (Social Service) stated R6 does think R15 is her boyfriend. V14 stated she has heard from multiple staff and residents that R6 and R15 are in a sexual relationship. V14 stated, The first time I heard about them having sex, (R6) was in the hospital. It was a couple of months ago. Since (R6) was in the hospital, it was after the fact, and I did not report it to (V1). V14 stated there was a recent Care Plan meeting with R6's parents, V4 and V15. V14 stated, The main topic of that meeting was (R6's) sexual relationship with (R15). V14 stated, (R6) is cognitively there, but she does have a State appointed guardian. I feel she (R6) is able to consent to a sexual relationship. On 2/01/23 at 2:58 pm, V15 (Social Services) stated she is aware that R6 and R15 are in a relationship, and she has heard from other residents that they have a sexual relationship. V15 could not recall exactly when she heard this, but she assumed V1 knew about it because it was talked about openly. V15 stated she could not recall exactly what was discussed at the December 2022 Care Plan meeting with R6's parents and V4. V4 stated she is unsure if anything has been done to stop R6 and R15 from having a sexual relationship, stating, I'm not here at night, so I don't know what's done when I'm gone. I assumed (V1) would handle that, but (R6) can consent to a sexual relationship if she wants. <b[TRUNCATED]

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 23028 Based on interview and record review, the facility failed to implement their Abuse Prevention Program, which requires the immediate reporting and investigation of all allegations of abuse, the immediate suspension of individuals alleged to have committed abuse, the immediate protection a residents from further abuse, and the investigation of injuries of unknown origin that could have been abusive in nature, for eight of 12 residents reviewed (R6, R10, R11, R12, R13, R3, R1, R5) for abuse in a sample of 25. These failures have the potential to affect all 116 residents that currently reside in the facility. Findings include: (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility policy, titled Abuse Prevention Program (updated 11/28/16) defines Abuse: Abuse is the willful injection of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes the deprivation by 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 physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. The policy documents under, IV. Internal Reporting Requirements and Identification of Allegations: Employees are required to immediately report any occurrences of potential/alleged mistreatment, exploitation, neglect, and abuse of residents and misappropriation of resident property they observe, hear about, or suspect to a supervisor and the administrator. All residents, visitors, volunteers, family members or others are encouraged to report their concerns or suspected incidents of potential/alleged mistreatment, exploitation, neglect, and abuse of residents and misappropriation of resident property to a supervisor and administrator. Such reports may be made without fear of retaliation. Anonymous reports will also be thoroughly investigated. Supervisors shall immediately inform the administrator or his/her designated representative (specified by the administrator in the case of a planned absence) of all reports of potential/alleged mistreatment, exploitation, neglect, and abuse of residents and misappropriation of resident property. Upon learning of the report, the administrator or designee shall initiate an investigation. The nursing staff is additionally responsible for reporting on a facility incident report the appearance of bruises, lacerations, other abnormalities, or injuries of unknown origin as they occur. Upon report of such occurrences, the nursing supervisor is responsible for assessing the resident, reviewing the documentation and reporting to the administrator or designee. If the resident complains of physical injuries or if resident harm is suspected, the resident physician will be contacted for further instructions. Protection of Residents: The facility will take steps to prevent mistreatment, exploitation, neglect, and abuse of residents and misappropriation of resident property while the investigation is underway. Residents who allegedly mistreat or abuse another resident or misappropriate resident property will be removed from contact with that resident during the course of the investigation. The accused resident's condition shall be immediately evaluated to determine the most suitable therapy, care approaches and placement considering his or her safety, as well as the safety of other residents and employees of the facility. Accused individuals not employed by the facility will be denied unsupervised access to the resident during the course of the investigation. Employees of this facility who have been accused of mistreatment, exploitation, neglect, abuse or misappropriation of resident property will be immediately removed from resident contact until the results of the investigation have been reviewed by the administrator or designee. Employees accused of alleged mistreatment, exploitation, neglect, abuse or misappropriation of resident property shall not complete their shift as a direct care provider to residents. VI. Internal Investigation of Allegations and Response: 1. Appointing an Investigator. Once the administrator or designee receives an allegation of mistreatment, exploitation, neglect or abuse, including injuries of unknown source and misappropriation of resident property; the administrator will appoint a person to take charge of the investigation. The person in charge of the investigation will obtain a copy of any documentation relative to the incident and follow the Resident Protection Investigation Procedures. 2. Following the Resident Protection Investigation Procedures. The appointed investigator will follow the Resident Protection Investigation Procedures, attached to this policy. The Procedures contain specific investigation paths depending on the nature of the allegation, procedures for investigation, interview parameters, and reporting requirements. 3. Confidentiality. The investigator shall do as much as possible to protect the identities of any employees and residents involved in the investigation until the investigation is concluded. After a conclusion based on the facts of the investigation is determined, internal reports, interviews and witness statements shall be released only with the permission of the administrator or the facility attorney. Even if the facility investigation is not complete the administrator will cooperate with any Department of Public Health investigation into the matter. 4. Updates to the Administrator. The person in charge of the investigation will update the administrator or designee during the progress of the investigation. The administrator or designee will keep the resident or resident's representative informed of the progress of

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1. A Grievance/Complaint Report, dated 1/05/23 and completed by V4 (Social Services Director), documents R6 complained (R9) rubbing on her butt, putting arm around her (and) saying 'Baby, give me a kiss,' touched her breast, looked up her dress. Also, going up (and) down A Hall (at) night, (R6) claimed, 'I can hear (R9) through the wall.' Resident Council Meeting minutes dated 1/10/23 document (R9) needs to be on a 1 on 1 at all times, overnights too. Residents are not comfortable in his presence and are scared of him. (R9) is very violent, overly sexual, calling names, going through resident's rooms, (R10, R6, R11 and R12) have all brought attention to this. A Resident Council Concern/Complaint form, dated 1/10/23 by V16 (Activities Director), documents Residents would also like if (R9) was out of the facility because they feel unsafe. A documented summary of V10's (Ombudsman) notes from the 1/10/23 Resident Council Meeting include the following information: Other concerns: (R9) is touching and grabbing women in a sexual behavior. (R9) is pinning residents against walls and counters as well. (R6) stated that (R9) has looked up her skirt, grabbed her breast, and rubbed his penis on her many times. It was stated in resident council that (R9) does not have a 1:1 anymore, and (R13 stated R9) touched my boobs and rubbed his penis on me, and (R11 stated R9) is getting into peoples' faces and personal space and touching the way she don't want to be touched. On 1/24/23 at 3:15 pm, V4 (Social Services Director) stated R6 told her on 1/05/23 that R9 was rubbing on her butt, breast and saying inappropriate sexual statements to her, wanting a kiss and telling her to drop that a**. According to V4, R6 stated she could hear R9 wandering the halls at night, all night, going into others' rooms. V4 stated R6 was very upset over the fact that R9 had been on 1:1 supervision in the past for similar behavior but was taken off 1:1 supervision and was allowed to do this to her. V4 stated she wrote up the statement from R6 on 1/05/23 and then took it to morning meeting with all the Department Heads on 1/06/23 to be discussed. On 1/26/23 at 8:15 am, V10 (Ombudsman) stated she attended the most recent Resident Council Meeting (1/10/23). V10 stated R6 verbalized in the Resident Council Meeting R9 rubbed his penis on her and rubbed her boobs and other female residents complained about R9 being sexually inappropriate with them. On 1/30/23 at 10:18 am, R6 was interviewed over the phone, as she was admitted to the hospital. R6 stated R9 touches my boobs, tries to kiss me, and will come up to me and rub his penis on me through his clothes. (R9) will hold on to me from behind. It makes me feel uncomfortable and this happens almost every single day. R6 stated R9 will call her names, like N****r, C**t, and B***h when she pushes him away. On 1/25/23 at 12:59 PM, V1 denied knowledge of the 1/05/23 grievance completed by V4 regarding R6 and R9. V1 confirmed that she was in attendance for the Resident Council meeting on 1/10/23. V1 stated she did not interview the four female residents that spoke out about R9's sexual behavior in the Resident Council Meeting. V1 stated, I recall (R6) speaking out against (R9) and (R10) as well. I do not remember the other two residents having specific concerns with (R9). I can't tell you my exact immediate follow up. I did not interview any residents that had concerns. At some point, I had a conversation with (R6 about R9), but I do not know when and did not document the details. On 1/30/23 at 9:17 am, V1 stated in a follow up interview she has still not initiated any kind of formal investigation into the sexual abuse allegations reported to her last week involving R9. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. An official court document, dated 4/10/2017 documents V30 (R6's Mother) and V37 (R6's Father) as being appointed Guardians of the Estate & Person of (R6), a disabled adult, and are authorized to have, under direction of the Court, the care, management, and investment of the ward's estate and the custody of the ward, and to do all acts required by them by law. Physician's Orders, dated 1/01/23, document R6 has the current diagnoses of Anxiety, Schizoaffective Disorder, Intellectual Disability, and Chronic Post Traumatic Stress Disorder. On 1/31/23 at 1:05 pm, V10 (Ombudsman) stated V30 (R6's Mother) contacted her today, very upset and concerned about R6 being in a sexual relationship with a male resident in the facility. V10 stated V30 discussed this with the Social Services Department in December, but the facility was not doing anything to stop R6 from having sexual intercourse with this resident. V30 stated the concern is that R6 does not have the mental capacity to consent to a sexual relationship with someone. On 2/02/23 at 1:30 pm, V30 stated she reviewed her phone records and she spoke with V1 on 11/08/22 about R6 and R15 having sex. V30 stated V1 told her R6's BIMS (Brief Interview for Mental Status) was too high, and they were able to consent to a sexual relationship. V30 stated she told V1 that she did not agree, as (R6) has the mentality of a teenage girl, and there is a reason I'm her legally appointed Guardian. On 2/02/23 at 1:59 pm, V4 (Social Services Director) stated V4 talked to both R6 and R15's families regarding their sexual relationship in December, but (R6 and R15) had a high enough BIMS, so they could not stop them. V4 stated, (V1) was fully aware (of their sexual relationship); she has talked to (R6 and R15's) family regarding this. V4 stated they did discuss developing a care plan with individualized interventions to keep R6 and R15 from having sexual relations, but that never transpired. On 2/01/23 at 2:33 pm, V14 (Social Service) stated she has heard from multiple staff and residents that R6 and R15 are in a sexual relationship. V14 stated, The first time I heard about them having sex, (R6) was in the hospital. It was a couple of months ago. Since (R6) was in the hospital, it was after the fact, and I did not report it to (V1). V14 stated there was a recent Care Plan meeting with R6's parents, V4 and V15. V14 stated, The main topic of that meeting was (R6's) sexual relationship with (R15). On 2/01/23 at 3:55 pm, V1 stated she did not have an investigation initiated regarding R6 and R15's sexual relationship. 3. Resident Council Meeting minutes, dated 1/10/23 document the following concerns: LPN (is) stealing narcotics, CNAs (Certified Nursing Assistants) yelling at residents is not okay and needs to stop, and (CNAs) retaliating with residents when they have an issue with things. (continued on next page)

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	146097	A. Building B. Wing	02/23/2023

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A Resident Council Concern Form, completed by V16 (Activities Director) on 1/10/23, documents Department: Administration, under Concern/Complaint it states in the notes section, CNAs and nurses are retaliating when they (residents) bring issues to them that staff does not agree with, and (R2) also brought up LPNs (Licensed Practical Nurses) stealing narcotics. A Resident Council Concern Form, completed by V16 (Activities Director) on 1/18/23, documents Department: CNAs, under Concern/Complaint: Residents believe that the CNAs yelling at residents is not okay, and They are also concerned that the CNAs are retaliating when the residents bring up issues to them that they do not agree with. A Resident Council Concern Form, completed by V16 (Activities Director) on 1/10/23, documents Department: Nursing, under Concern/Complaint: Certain Nurses are retaliating against residents who give them issues. A documented summary of V10's (Ombudsman) notes from the 1/10/23 Resident Council Meeting include the following information: (Nursing Staff) ignore residents when residents need help. One resident stated the less cognitive a resident is the worse it is for them, Residents being forced to stay in their rooms or go to their rooms, It was stated that when (R3) had a fainting episode staff makes fun of him because the staff think he is faking it (V11/Registered Nurse is the main one), (R3 stated) backlash is horrible from staff. Nurses get in your face and say f**k you, you're going to your room. Resident is staying in his room due to being uncomfortable. On 1/26/23 at 8:15 am, V10 (Ombudsman) stated she was present for the 1/10/23 Resident Council Meeting and several residents attended. V10 stated V1 (Administrator in Training) and V2 (Assistant Administrator in Training) were present for the entire meeting. V10 stated R2, who is the Resident Council [NAME] President, was voicing most of the concerns, and R2 even had all his concerns typed up, giving everyone a copy. V10 stated other residents were agreeing with R2's issues brought forth. V10 stated several resident concerns were abusive in nature. V10 stated R2 verbalized he has witnessed nursing staff, specifically V3 (Resident Care Coordinator), take resident medications home with her after she dispenses medication from the pill sleeve. V10 stated multiple residents complained of staff retaliating when they complain about something, staff will be mean to them, make fun of residents, and yell at them. R2's documented Grievance List from 1/10/23, provided by V10 (Ombudsman), documents the following statements: (Licensed Practical Nurse, name withheld) pulls meds, while pulling meds, when she grabs meds out of lock box (for narcotics), she pops all meds into dispensing cup, except the narcotic, it gets popped onto the top of (the medication) cart and slipped into her pocket. On 1/24/23 at 3:45 pm, V16 (Activities Director) stated multiple concerns were brought up at the 1/10/23 Resident Council Meeting, which she documented and gave to V1. V16 confirmed that V1 and V2 were present for the meeting that day. V16 stated that staff retaliation against residents was mentioned by R2, but he didn't expand on it. V16 stated residents indicated they had observed nursing staff popped the narcotic pill out, put it to the side of the medication cart, then slide it into her pocket. V16 recalled R2 stating that if residents do something that the CNAs don't like, they will raise their voices at them. On 1/25/23 at 12:59 pm, V1 confirmed that she was present for the 1/10/23 Resident Council Meeting and she had received a copy of the 1/10/23 Resident Council Meeting notes. As a response to those concerns, V1 stated, I still want to go through and talk to residents; when I get complaints, I don't always jump. V1 stated she did not do a formal investigation into any concerns brought forth by the residents regarding abuse, retaliation or stealing of narcotics. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 1/30/23 at 9:17 am, V1 stated in a follow up interview she has still not initiated an investigation into the misappropriation of resident property (stealing narcotics). 4. On 1/26/23 at 8:15 am, V10 (Ombudsman) stated 1/19/23, she informed V1 (Administrator in Training) that R3 had reported to her V27 (Licensed Practical Nurse) was hitting him in the leg when she passes medication and that V3 (Licensed Practical Nurse/Resident Care Coordinator) had yelled at R3 a few days prior. V10 said she specifically told V1 that R3 reported to her V3 yelled at him to Shut the f**k up and threatened to call the police on him. V10 stated V1 informed her that she had already spoken to V3 about the situation and that was not what had happened. V10 stated she was concerned that V1 did not report or investigate this allegation of abuse. On 1/24/23, at 10:33 am, R3 stated on 1/16/23 he had been waiting for his noon medications at the Nurses' Station for about 20 minutes. R3 stated V3 (Resident Care Coordinator) started walking away with the medication cart, heading to the dining room. R3 stated he spoke up and told V3 he didn't get his noon medication. R3 stated V3 told him that he would have to follow her to the dining room if he wanted his medicine. R3 stated he did state, Are you kidding me? as he had been waiting for 20 minutes and prefers not to take all his medication in the dining room. R3 stated another resident (R16) was waiting for her medicine at the nurses' station with him and had to follow V3 into the dining room. According to R3, once he and R16 entered the dining room and waited by the medication cart, V3 informed R16 she would now have to wait again for V3 to return to the nurses' station to receive her medication, because not all her medicine was in the medication cart, and she needed to access the medication room. R3 stated he did speak up and told V3 this wouldn't have happened had she just given them their medicine when they were waiting at the nurses' station. According to R3, at that point V3 leaned across the (medication) cart, towards me, and started yelling at me to 'shut the f**k up and leave' and when I didn't, she said 'get the f**k out or I'm calling the police. R3 stated he immediately told V1, who was in her office just outside of the dining room, what V3 yelled at him. R3 stated multiple other CNAs were present in the dining room when it happened and there are cameras in the area. R3 stated V3 stayed working in the facility the remainder of the day and he asked for a different nurse to give him is medication. R3 stated he also reported to V10 that V27 (Licensed Practical Nurse) will wake him up by smacking his leg to give him his medication. R3 stated he gave V10 permission to report that to V1, which she did that same day. R3 stated, Nothing was done about (V27) though; (V1) never even asked me about it. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 1/24/23 at 12:10 pm, V1 stated about one week ago, V3 came to her asking for help with R3, because of his behaviors. Immediately after that, R3 came to her and stated V3 had yelled at him when he was trying to get his medications that day during lunch. V1 stated R3 and V3's stories did coincide, apart from V3 denying yelling at R3. V1 stated she was in her office at the time this incident occurred, and her door was cracked, but she did not hear any yelling. V1 stated she did hear R3's voice elevated, but he has a loud voice, and does not know what he said. V1 stated R3 told her that V3 threatened to call the police on him if he didn't step away from her medication cart and that she yelled at him to get the f**k out of my face. V1 stated R3 admitted to her that he could have provoked V3. V10 stated V3 admitted that she firmly told (R3) to step away from her but denied cursing at him or yelling. V1 stated she did interview three CNAs that were in the area at the time of the alleged incident, along with V2 (Assistant Administrator in Training), who denied hearing V3 yell at R3. V1 stated she did not interview any residents that were in the dining room at that time, and V3 worked the remainder of the day without being suspended. V1 stated she would consider the statement get the f**k out of my face towards a resident abusive but considered the allegation at the time a grievance and did not report the incident or formally investigate it. V1 admitted there is surveillance footage she could have looked at in the dining room but did not. V1 confirmed that a couple of days later, the Ombudsman did speak to her about R3's allegations that V3 had yelled at him and stated get the f**k out of my face and his concerns with V27. V1 indicated she did not have any documented evidence of interviewing V3, R3 or the CNAs that were present in the dining room at the time of the alleged incident. On 1/24/23, R3's medical record contained no documentation related to his allegations of abuse. On 1/30/23 at 9:17 am, V1 stated she had still not initiated a formal investigation into R3's abuse allegations. 5. R1's TAR (Treatment Administration Record) dated 1/23, documents that R1 requires daily skin checks. The TAR has no documentation of these daily checks being completed on 1/13/23-1/16/23. R1's Hospitalist Admission History and Physical, dated 1/17/23, documents, R1 with severe schizophrenia, tardive dyskinesia, seizure disorder, brought in from facility with complaints of lethargy and worsening tremors. She has not been taking her medication in the facility. R1 is lethargic, barely responsive. Physical exam: Skin, hair, nails: Ecchymosis in various stages of healing on bilateral legs and inner thighs. R1's Hospital History and Physical, dated 1/17/23, documents, Assessment/Plan: Multiple bruises especially lower extremities, present on admission. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 1/24/22 at 2:45 p.m., V13 (Hospital Registered Nurse) stated, I got concerned when I saw (R1's) bruising on her inner thighs that looked like fingerprints. The bruising was in the shape and pattern of fingers. There are pictures of the bruising in her chart that we took. She also had bruising on the outside of both of her hips in the same spot and in a circle like the size of a dollar coin. These bruises were not brand-new bruises; some of it was starting to fade out and had some yellow coloring. The facility was notified of the bruising by our staff the day she was admitted . I did not call the facility, but someone else did and the facility told them that they were not aware of any bruising on (R1). The facility stated when (R1) is in her room by herself she rests peacefully. Then, once we enter her room she starts shaking, her lips quiver, and she acts anxious and scared. When I went to change her (incontinence) brief she instantly squeezes her legs together tightly and gets nervous. It's like she's scared something is going to happen when we care for her. On 1/25/23 at 12:59 pm, V1 (Administrator in Training) stated, I'm unaware that the hospital reported any bruising injury to my staff for (R1). State surveyor reported R1's bruising at this time. On 1/26/22 at 12:00 p.m., V1 retrieved R1's hospital records on V1's computer. V1 received the photos of R1's bruising to R1's bilateral inner thighs. R1's Hospital Records document a photo of R1's left and right inner thighs. R1's left inner thigh has bruising in the shape of two lines, one being the length of half of R1's thigh. The bruising is located directly in the middle of R1's left thigh. R1's right inner thigh bruising is located from the middle of her thigh to the back of her knee area. R1 has a large circular bruise, and a bruise in a linear shape as well. On 1/26/22 at 1:30 pm, V1 stated, I've just started an investigation on (R1's) bruising. I've talked to staff, and they have all stated that R1 has had bruising on her legs and thighs before from putting herself on the floor and running into things. When I spoke with staff I didn't probe to ask specifically about her inner thighs. I asked a general question of where her bruising is located. (V8/Certified Nursing Assistant/CNA) and (V17/CNA) were interviewed, and both stated that (R1) had bruising on her inner thighs. I don't suspect sexual abuse whatsoever. On 1/26/23 at 2:00 pm, V17 (CNA) stated, I've seen bruising on (R1's) legs and arms. I've never seen any bruising on her inner thighs. V17 was showed the pictures from the hospital. V17 gasped and said Oh no, I have never seen any bruising like that. She wouldn't have bruising like that from the stuff she does that she gets bruises from. On 1/26/22 at 2:10 p.m., V8 (CNA) stated, I've seen bruising on R1's legs and arms before, especially her shins. She puts herself on the floor and falls a lot. V8 was shown the pictures of R1's bruising. With a surprised look on her face, V8 stated, No she's never had bruising like that! I've never seen bruising on her inner thighs before. A report to the State Agency, dated 2/3/23, documents, Original Allegation: State Surveyors reported to V1 that hospital reported to the State Agency bruising of unknown origin to lower extremities of resident signifying sexual abuse. Account: Police department, physician, and responsible party were immediately notified of allegation. Staff were interviewed of noted bruising on resident. Staff stated that bruising has been noted due to resident repeatedly putting self on floor and self-harming by hitting legs with bathroom door during moments of agitation. Determination/Conclusion: It is determined that the allegation of sexual abuse is unfounded. It is determined that the resident commits self-harm during episodes of agitation which is care planned. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	6. On 1/24/23 at 11:50 a.m., R5 was alert but nonverbal sitting up on the side of her bed. R5 had a purple and yellow bruise with swelling to the outer corner of R5's right eye. R5's MDS (Minimum Data Set), dated 11/20/22, documents R5's BIMs (Brief Interview for Mental Status) had a score of 99 (severely impaired cognition). On 1/24/23 at 2:20 p.m., V17 (CNA) stated, I saw (R5's) bruise on her eye this morning and asked what happened. (V8/CNA) was sitting there with (R5) and said (R5) has had the bruise for a few days. V11 (Registered Nurse) was present as well and stated, (R5) has a bruise on her eye? I didn't even notice she had a bruise, and I gave her medicine today. On 1/24/22 at 4:30 p.m., V11 stated, Yeah I guess (R5) does have a bruise on her eye. Supposedly, (V8) knew for a few days that (R5) had the bruise. I worked the weekend and (V8) never told me about it. I haven't done any kind of report on it. I reported it to (V1/Administrator in Training) today. On 1/26/23 at 2:10 p.m., V8 (CNA) stated, Monday night (1/23/23) at dinner time was the first time I saw (R5's) bruise on her eye. I heard (R5) had ran into a wall or something like that. I didn't talk to anyone because I assumed it was already documented as a fall. On 1/25/23 at 12:59 pm, V1 stated, Staff did report to me just this morning that (R5) does have a bruise to her eye. They (Nursing) are thinking the injury is from her head resting on her headboard and she moves around. They (Nursing) are going to try to come up with an intervention. I'm just going with what the nurse told me and going with that. I have not talked to any other staff regarding the injury and was not going to d[TRUNCATED]

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 23028 Based on interview and record review, the facility failed to ensure all allegations of sexual abuse, verbal abuse, physical abuse, misappropriation of resident property and suspicious injuries of unknown origin were immediately reported to the facility Administrator and/or State Agency, for eight of 12 residents (R1, R3, R5, R6, R10, R11 and R12) reviewed for abuse in a sample of 25. These failures have the potential to affect all 116 residents that currently reside in the facility. Findings include: The facility policy, titled Abuse Prevention Program (revised 11/282016) documents VII. External Reporting of Potential Abuse: 1. Initial Reporting of Allegations - The facility must ensure that all alleged violations involving mistreatment, exploitation, neglect or abuse, including injuries of unknown source, misappropriation of resident property, and reasonable suspicion of a crime, are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures. If the events that cause the reasonable suspicion result in serious bodily injury or suspected criminal sexual abuse, the report shall be made to at least one law enforcement agency of jurisdiction and IDPH (Illinois Department of Public Health) immediately after forming the suspicion (but not later than two hours after forming the suspicion). Otherwise, the report must be made not later than 24 hours after forming the suspicion. A written report shall be sent to the Department of Public Health. The written report should contain the following information, if known at the time of the report: Name, age, diagnosis, and mental status of the resident allegedly abused or neglected; Type of abuse reported (physical, sexual, theft, neglect, exploitation, verbal, or mental abuse); Date, time, location, and circumstances of the alleged incident; Any obvious injuries or complaints of injury; and steps the facility has taken to protect the resident. The administrator or designee will also inform the resident or resident's representative of the report of an occurrence of potential mistreatment, exploitation, neglect, and abuse of residents and misappropriation of resident property and that an investigation is being conducted. 2. Five-day Final Investigation Report. Within five working days after the report of the occurrence a complete written report of the conclusion of the investigation, including steps the facility has taken in response to the allegation, will be sent to the Department of Public Health. The Public Health requirements for a final investigation report are detailed in paragraph 5 of the Internal Investigations section of this procedure. 1. A Grievance/Complaint Report, dated 1/05/23 and completed by V4 (Social Services Director), documents R6 complained (R9) rubbing on her butt, putting arm around her (and) saying 'Baby, give me a kiss,' touched her breast, looked up her dress. Also, going up (and) down A Hall (at) night, (R6) claimed, 'I can hear (R9) through the wall.' Resident Council Meeting minutes, dated 1/10/23 document (R9 is) very violent, overly sexual, calling names, going through resident's rooms, (R10, R6, R11 and R12) have all brought attention to this. A Resident Council Concern/Complaint form, dated 1/10/23 by V16 (Activities Director), documents Residents would also like if (R9) was out of the facility because they feel unsafe. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A documented summary of V10's (Ombudsman) notes from the 1/10/23 Resident Council Meeting include the following information: Other concerns: (R9) is touching and grabbing women in a sexual behavior. (R9) is pinning residents against walls and counters as well. (R6) stated that (R9) has looked up her skirt, grabbed her breast, and rubbed his penis on her many times, (R13 stated R9) touched my boobs and rubbed his penis on me, and (R11 stated R9) is getting into people faces and personal space and touching in the way she don't want to be touched. On 1/24/23 at 3:15 pm, V4 (Social Service Director) stated R6 told her on 1/05/23 that R9 was rubbing on her butt, breast and saying inappropriate sexual statements to her, wanting a kiss and telling her to drop that a**. According to V4, she did not immediately report this allegation to V1. V4 stated she wrote up the statement from R6 on 1/05/23 and then took it to morning meeting the next day with all the Department Heads and V1 to be discussed. On 1/25/23 at 12:59 PM, V1 (Administrator in Training) denied knowledge of the 1/05/23 grievance completed by V4 regarding R6 and R9. V1 confirmed that she was in attendance for the Resident Council meeting on 1/10/23. V1 stated she did not report to the State Agency the allegations made by the four female residents that spoke out about R9's sexual behavior in the Resident Council Meeting. V1 stated, I recall (R6) speaking out against (R9) and (R10) as well. I do not remember the other two residents having specific concerns with (R9). I can't tell you my exact immediate follow up. I did not interview any residents that had concerns. At some point, I had a conversation with (R6 about R9), but I do not know when and did not document the details. On 1/30/23 at 9:17 am, V1 stated in a follow up interview she had still not reported to the State Agency the sexual abuse allegations reported to her last week involving R9. 2. Resident Council Meeting minutes, dated 1/10/23 document the following concerns: LPN (is) stealing narcotics, CNAs (Certified Nursing Assistants) yelling at residents is not okay and needs to stop, and (CNAs) retaliating with residents when they have an issue with things. A Resident Council Concern Form, completed by V16 (Activities Director) on 1/10/23, documents Department: Administration, under Concern/Complaint it states in the notes section, CNAs and nurses are retaliating when they (residents) bring issues to them that staff does not agree with, and (R2) also brought up LPNs (Licensed Practical Nurses) stealing narcotics. A Resident Council Concern Form, completed by V16 (Activities Director) on 1/18/23, documents Department: CNAs, under Concern/Complaint: Residents believe that the CNAs yelling at residents is not okay, and They are also concerned that the CNAs are retaliating when the residents bring up issues to them that they do not agree with. A Resident Council Concern Form, completed by V16 (Activities Director) on 1/10/23, documents Department: Nursing, under Concern/Complaint: Certain Nurses are retaliating against residents who give them issues. A documented summary of V10's (Ombudsman) notes from the 1/10/23 Resident Council Meeting include the following information: Residents being forced to stay in their rooms or go to their rooms; It was stated that when (R3) had a fainting episode staff makes fun of him because the staff think he is faking it. (V11/Registered Nurse) (is the main one); (R3 stated) backlash is horrible from staff. Nurses get in your face and saying f**k you, you're going to your room. Resident is staying in his room due to being uncomfortable. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 1/26/23 at 8:15 am, V10 (Ombudsman) stated she was present for the 1/10/23 Resident Council Meeting and several residents attended. V10 stated V1 (Administrator in Training) and V2 (Assistant Administrator in Training) were present for the entire meeting. V10 stated several resident concerns were abusive in nature, including verbal and sexual abuse. V10 stated R2 verbalized he has witnessed nursing staff, specifically V3 (Resident Care Coordinator), take resident medications home with her after she dispenses medication from the pill sleeve. V10 stated multiple residents complained of staff retaliating when they complain about something, staff will be mean to them, make fun of residents, and yell at them. R2's documented Grievance List from 1/10/23, provided by V10, documents the following statements: (Licensed Practical Nurse, name withheld) pulls meds, while pulling meds, when she grabs meds out of lock box (for narcotics), she pops all meds into dispensing cup, except the narcotic, it gets popped onto the top of (the medication) cart and slipped into her pocket. On 1/24/23 at 3:45 pm, V16 (Activities Director) stated multiple concerns were brought up at the 1/10/23 Resident Council Meeting, which she documented and gave to V1. V16 confirmed that V1 and V2 were present for the meeting that day. V16 stated that staff retaliation against residents was mentioned by R2, but he didn't expand on it. V16 stated residents indicated they had observed nursing staff popped the narcotic pill out, put it to the side of the medication cart, then slide it into her pocket. V16 recalled R2 stating that if residents do something that the CNAs don't like, they will raise their voices at them. On 1/25/23 at 12:59 pm, V1 (Administrator in Training) confirmed that she was present for the 1/10/23 Resident Council Meeting and she had received a copy of the 1/10/23 Resident Council Meeting notes. As a response to those concerns, V1 stated, I still want to go through and talk to residents. When I get complaints, I don't always jump. V1 stated she did not report to the State Agency any concerns brought forth by the residents regarding abuse, retaliation or stealing of narcotics. On 1/30/23 at 9:17 am, V1 stated in a follow up interview she has still not reported to the State Agency any of the issues verbalized or documented during the January Resident Council Meeting that involved verbal abuse, staff retaliation or stealing of narcotics. 3. On 1/26/23 at 8:15 am, V10 (Ombudsmen) stated on 1/19/23, she informed V1 that R3 had reported to her V27 (Licensed Practical Nurse) was hitting him in the leg when she passes medication and that V3 (Licensed Practical Nurse/Resident Care Coordinator) had yelled at R3 a few days prior. V10 said she specifically told V1 that R3 reported to her V3 yelled at him to Shut the f**k up and threatened to call the police on him. V10 stated V1 informed her that she had already spoken to V3 about the situation and that was not what had happened. V10 stated she was concerned that V1 did not report or investigate this allegation of abuse. On 1/24/23, at 10:33 am, R3 stated on 1/16/23 after he had verbalized his concerns to V3 over the noon medication pass, V3 leaned across the (medication) cart, towards me, and started yelling at me to 'shut the f**k up and leave' and when I didn't, she said 'get the f**k out or I'm calling the police. R3 stated he immediately told V1 (Administrator in Training) what V3 yelled at him. R3 stated he also reported to V10 (Ombudsman) that V27 (Licensed Practical Nurse) will wake him up by smacking his leg to give him his medication. R3 stated he gave V10 permission to report that to V1, which she did that same day. R3 stated, Nothing was done about (V27) though. (V1) never even asked me about it. (continued on next page)

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	146097	A. Building B. Wing	02/23/2023

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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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 1/24/23 at 12:10 pm, V1 confirmed, about one week ago, R3 came to her and stated V3 had yelled at him when he was trying to get his medications that day during lunch. V1 stated she would consider the statement get the f**k out of my face towards a resident abusive but considered the allegation at the time a grievance and did not report the incident to the State Agency or formally investigate it. V1 confirmed that a couple of days later, the Ombudsman did speak to her about R3's allegations that V3 had yelled at him and stating get the f**k out of my face and his concerns with V27. V1 indicated she still did not report the incidents to the State Agency. On 1/30/23 at 9:17 am, V1 stated she had still not initiated a formal investigation into R3's abuse allegations. 4. R1's Hospitalist Admission History and Physical, dated 1/17/23, documents, R1 with severe schizophrenia, tardive dyskinesia, seizure disorder brought in from facility with complaints of lethargy and worsening tremors. She has not been taking her medication in the facility. R1 is lethargic, barely responsive. Physical exam: Skin, hair, nails: Ecchymosis in various stages of healing on bilateral legs and inner thighs. R1's Hospital History and Physical, dated 1/17/23, documents, Assessment/Plan: Multiple bruises especially lower extremities, present on admission. On 1/24/22 at 2:45 p.m., V13 (Hospital Registered Nurse) stated, I got concerned when I saw (R1's) bruising on her inner thighs that looked like fingerprints. The bruising was in the shape and pattern of fingers. There are pictures of the bruising in her chart that we took. She also had bruising on the outside of both of her hips in the same spot and in a circle like the size of a dollar coin. These bruises were not brand-new bruises; some of it was starting to fade out and had some yellow coloring. The facility was notified of the bruising by our staff the day she was admitted . I did not call the facility, but someone else did and the facility told them that they were not aware of any bruising on (R1). On 1/25/23 at 12:59 pm, V1 (Administrator in Training) stated, I'm unaware that the hospital reported any bruising injury to my staff for (R1). State surveyor reported R1's bruising at this time. On 1/26/22 at 12:00 p.m., V1 retrieved R1's hospital records on V1's computer. V1 received the photos of R1's bruising to R1's bilateral inner thighs. R1's Hospital Records document a photo of R1's left and right inner thighs. R1's left inner thigh has bruising in the shape of two lines, one being the length of half of R1's thigh. The bruising is located directly in the middle of R1's left thigh. R1's right inner thigh bruising is located from the middle of her thigh to the back of her knee area. R1 has a large circular bruise, and a bruise in a linear shape as well. V1 confirmed she had not reported to the State Agency any Injuries of Unknown Origin for R1. 5. On 1/24/23 at 11:50 a.m., R5 was alert but nonverbal sitting up on the side of her bed. R5 had a purple and yellow bruise with swelling to the outer corner of R5's right eye. R5's MDS (Minimum Data Set), dated 11/20/22, documents R5's BIMs (Brief Interview for Mental Status) had a score of 99 (severely impaired cognition). (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 1/24/23 at 2:20 p.m., V17 (Certified Nursing Assistant/CNA) stated, I saw (R5's) bruise on her eye this morning and asked what happened. (V8/CNA) was sitting there with (R5) and said (R5) has had the bruise for a few days. V11 (Registered Nurse) was present as well and stated, (R5) has a bruise on her eye? I didn't even notice she had a bruise, and I gave her medicine today. On 1/24/22 at 4:30 p.m., V11 (Registered Nurse) stated, Yeah I guess (R5) does have a bruise on her eye. Supposedly, (V8) knew for a few days that (R5) had the bruise. I worked the weekend and (V8) never told me about it. I haven't done any kind of report on it. I reported it to (V1/Administrator in Training) today. On 1/26/23 at 2:10 p.m., V8 (CNA) stated, Monday night (1/23/23) at dinner time was the first time I saw (R5's) bruise on her eye. I heard (R5) had ran into a wall or something like that. I didn't talk to anyone because I assumed it was already documented as a fall. On 1/25/23 at 12:59 pm, V1 stated, Staff did report to me just this morning that (R5) does have a bruise to her eye. They (Nursing) are thinking the injury is from her head resting on her headboard and she moves around. They (Nursing) are going to try to come up with an intervention. I'm just going with what the nurse told me and going with that. I have not talked to any other staff regarding the injury and was not going to do an investigation. On 1/26/22 at 12:00 p.m., V1 confirmed she had not reported to the State Agency an injury of unknown origin for R5 at this time. The CMS-672 (Resident Census and Conditions of Residents), dated 1/24/23 and signed by V1 (Administrator in Training), documents 116 residents currently live in the facility.

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 23028 Based on observation, interview and record review, the facility failed to investigate an allegation of sexual abuse made by R6 against R9 (on 1/05/23) and protect R6 from potential further abuse, failed to investigate and implement measures to prevent an ongoing sexual relationship between a resident (R6, who lacks the mental capacity to legally consent) and R15, failed to investigate multiple allegations of abuse made by residents during Resident Council meetings, which included sexual abuse, verbal abuse, staff retaliation and misappropriation, and failed to investigate an allegation of verbal abuse made by R3 against V3 (Registered Nurse) on 1/24/23. Additionally, the facility failed to investigate inner thigh bruising found on R1's inner thighs and facial bruising found on R5, both injuries of unknown origin. These failures have the potential to affect all 116 residents that reside in the facility, as no measures were taken by V1 (Administrator in Training) to ensure residents within the facility were protected from potential further abuse. These failures resulted in an Immediate Jeopardy. While the immediacy was removed on 02/02/2023, the facility remains out of compliance at a Severity Level 2 as the facility's Quality Improvement Program conducts random audits to ensure facility staff's compliance with the Abuse Prevention Program, with an emphasis on Abuse Reporting, Investigation of Abuse Allegations, and staff's understanding of Abuse Prevention Training. Findings include: (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The Abuse Prevention Program policy (revised 11/28/2016), documents This facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined below. This includes, but is not limited to, freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This facility therefore prohibits mistreatment, exploitation, neglect or abuse of its residents, and has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment, exploitation, neglect or abuse of our residents. The policy later documents, The following definitions are based on federal and state laws, regulations and interpretive guidelines. Abuse: Abuse is the willful injection of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by 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 physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Adverse Event: An adverse event is an untoward, undesirable, and usually unanticipated event that causes death or serious injury, or the risk thereof. Exploitation means taking advantage of a resident for personal gain through the use of manipulation, intimidation, threats, or coercion. Physical Abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment. Sexual Abuse is non-consensual sexual contact of any type with a resident. Verbal Abuse is the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or families, or within their hearing distance regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to, threats of harm, or saying things to frighten a resident, such as telling a resident that he/she will never to be able to see his/her family again. Mental Abuse includes, but is not limited to, abuse that is facilitated or caused by nursing home staff taking or using photographs or recordings in any manner that would demean or humiliate a resident(s), harassment, humiliation and threats of punishment or deprivation. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident ' s belongings or money without the resident's consent. Mistreatment means inappropriate treatment or exploitation of a resident. Section IV of the policy documents, Internal Reporting Requirements and Identification of Allegations: Employees are required to immediately report any occurrences of potential/alleged mistreatment, exploitation, neglect, and abuse of residents and misappropriation of resident property they observe, hear about, or suspect to a supervisor and the administrator. All residents, visitors, volunteers, family members or others are encouraged to report their concerns or suspected incidents of potential/alleged mistreatment, exploitation, neglect, and abuse of residents and misappropriation of resident property to a supervisor and administrator. Such reports may be made without fear of retaliation. Anonymous reports will also be thoroughly investigated. Supervisors shall immediately inform the administrator or his/her designated representative (specified by the administrator in the case of a planned absence) of all reports of potential/alleged mistreatment, exploitation, neglect, and abuse of residents and misappropriation of resident property. Upon learning of the report, the administrator or designee shall initiate an investigation. The nursing staff is additionally responsible for reporting on a facility incident report the appearance of bruises, lacerations, other abnormalities, or injuries of unknown origin as they occur. Upon report of such occurrences, the nursing supervisor is responsible for assessing the resident, reviewing the documentation and reporting to the administrator or designee. If the resident complains of physical injuries or if resident harm is suspected, the resident physician will be contacted for further instructions. Section V of the policy documents, Protection of Residents: The facility will take steps to prevent mistreatment, exploitation, neglect, and abuse of residents and misappropriation of resident property while the investigation is underway. Residents who allegedly mistreat or abuse another resident or misappropriate resident property will be removed from contact with that resident during the investigation. The accused resident's condition shall be immediately evaluated to determine the most suitable therapy, care approaches and placement considering his or her safety, as well as the safety of other residents and employees of the facility. Accused individuals not employed by the facility will be denied unsupervised access to the resident during the course of the investigation. Employees of this facility who have been accused of mistreatment, exploitation, neglect, abuse or misappropriation of resident property will be immediately removed from resident contact until the results of the investigation have been reviewed by the administrator or designee. Employees accused of alleged mistreatment, exploitation, neglect, abuse or misappropriation of resident property shall not complete their shift as a direct care provider to residents. The policy further documents, under Section VI, Internal Investigation of Allegations and Response: 1. Appointing an Investigator. Once the administrator or designee receives an allegation of mistreatment, exploitation, neglect or abuse, including injuries of unknown source and misappropriation of resident property: the administrator will appoint a person to take charge of the investigation. The person in charge of the investigation will obtain a copy of any documentation relative to the incident and follow the Resident Protection Investigation Procedures. 2. Following the Resident Protection Investigation Procedures. The appointed investigator will follow the Resident protection Investigation Procedures, attached to this policy. The Procedures contain specific investigation paths depending on the nature of the allegation, procedures for investigation, interview parameters, and reporting requirements. 3. Confidentiality. The investigator shall do as much as possible to protect the identities of any employees and residents involved in the investigation until the investigation is concluded. After a conclusion based on the facts of the investigation is determined, internal reports, interviews and witness statements shall be released only with the permission of the administrator or the facility attorney. Even if the facility investigation is not complete the administrator will cooperate with any Department of Public Health investigation into the matter. 4. Updates to the Administrator. The person in charge of the investigation will update the administrator or designee during the progress of the investigation. The administrator or designee will keep the resident or resident's representative informed of the progress of the investigation. 5. Final Investigation Report. The investigator will report the conclusions of the investigation in writing to the administrator or designee within five working days of the reported incident. The policy documents, under Section VII, External Reporting of Potential Abuse: 1. Initial Reporting of Allegations. The facility must ensure that all alleged violations involving mistreatment, exploitation, neglect or abuse, including injuries of unknown source, misappropriation of

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The facility policy, titled Injuries of Unknown Origin (revised 4/18/16), documents All injuries of Unknown Origin will be investigated to determine the potential cause of the injury. Upon identification of the cause, interventions will be established to prevent any further injury by the IDT (Interdisciplinary Team) or Administration. All Injuries of Unknown origin will be discussed at the daily (Quality Assurance) meeting. The policy advises, Determine if the injury may be related to mistreatment of a resident: Bruising noted about the face or neck area; Bruising/reddened areas noted on wrists or lower forearms - similar to finger placement, or any part of the body that may indicate finger placement; Handprints/bruising noted to buttocks. The policy instructs staff to Identify and establish interventions for prevention of any further injuries: Possible Abuse - Begin following Abuse Prevention Program. 1. A Grievance/Complaint Report, dated 1/05/23 and completed by V4 (Social Services Director), documents R6 complained (R9) rubbing on her butt, putting arm around her (and) saying 'Baby, give me a kiss,' touched her breast, looked up her dress. Also, going up (and) down A Hall (at) night, (R6) claimed, 'I can hear (R9) through the wall.' Resident Council Meeting minutes dated 1/10/23 document (R9) needs to be on a 1 on 1 at all times, overnights too. Residents are not comfortable in his presence and are scared of him. (R9 is) very violent, overly sexual, calling names, going through resident's rooms, (R10, R6, R11 and R12) have all brought attention to this. A Resident Council Concern/Complaint form, dated 1/10/23 by V16 (Activities Director), documents Residents would also like if (R9) was out of the facility because they feel unsafe. A documented summary of V10's (Ombudsman) notes from the 1/10/23 Resident Council Meeting include the following information: Other concerns: (R9) is touching and grabbing women in a sexual behavior. (R9) is pinning residents against walls and counters as well. (R6) stated that (R9) has looked up her skirt, grabbed her breast, and rubbed his penis on her many times. It was stated in resident council that (R9) does not have a 1:1 anymore, and (R13 stated R9) touched my boobs and rubbed his penis on me. (R11 stated R9) is getting into people faces and personal space and touching the way she don't want to be touched. Upon entering the facility on 1/24/23 at 9:10 am, V1 (Administrator in Training) was asked for all the facility's Abuse Allegations investigated and reported to the Illinois Department of Public Health in the last 90 days. V1 provided three separate investigations, none of which involved R9, and indicated those were the only Abuse Allegation Investigations she had. On 1/24/23 at 3:15 pm, V4 (Social Service Director) stated R6 told her on 1/05/23 that R9 was rubbing on her butt, breast and saying inappropriate sexual statements to her, wanting a kiss and telling her to drop that a**. According to V4, R6 stated she could hear R9 wandering the halls at night, all night, going into others' rooms. V4 stated R6 was very upset over the fact that R9 had been on 1:1 supervision in the past for similar behavior but was taken off 1:1 supervision and was allowed to do this to her. V4 stated she wrote up the statement from R6 on 1/05/23 and then took it to morning meeting with all the Department Heads on 1/06/23 to be discussed. V4 stated V1 (Administrator in Training) and V2 (Assistant Administrator in Training) were present in that meeting. V4 stated she felt what R9 was doing to R6 was sexual abuse, but R9 doesn't have the ability to understand that his behavior is sexually inappropriate. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 1/24/23 at 3:45 pm, V16 (Activities Director) stated she typed the 1/10/23 Resident Council Meeting Minutes and then completed a form with each concern on it and delivered those concerns to the appropriate Department Head, including V1. V16 stated V1 was present at the 1/10/23 Resident Council Meeting, as she was invited by the residents due to all the concerns. V16 stated multiple residents brought up R9's behavior in that meeting, complaining that R9 is very sexual. (R9) will literally come up behind a person, grab their hips, get real close and dance with them. V16 stated residents complained that R9 would make sexual comments to people as well. They piped in and said (R9) had been overly sexual towards them. They didn't bring up specific times but chimed in when it was brought up. On 1/26/23 at 8:15 am, V10 (Ombudsman) stated she attended the most recent Resident Council Meeting (1/10/23). V10 confirmed that V1 and V2 were present for that meeting. V10 stated during the meeting, R6 and some other female residents complained about R9 being sexually inappropriate. V10 stated R6 verbalized in the Resident Council Meeting R9 rubbed his penis on her and rubbed her boobs. On 1/25/23 at 10:34 am, R11 stated she did complain at the Resident Council Meeting this month about (R9). R11 stated, (R9) will get in my face and yell real loud at me, saying all sorts of mean stuff. R11 stated this had been going on for awhile and staff would see it happening and do nothing. R11 then stated, (R9) has touched me, but I don't want to say where; he scares me. On 1/30/23 at 10:18 am, R6 was interviewed over the phone, as she was admitted to the hospital. R6 stated R9 touches my boobs, tries to kiss me, and will come up to me and rub his penis on me through his clothes. (R9) will hold on to me from behind. It makes me feel uncomfortable and this happens almost every single day. R6 stated R9 will call her names, like N****r, C**t, and B***h when she pushes him away. R6 stated the problems with R9 started over a year ago, and she has told many staff, including V1 (Administrator in Training), V2 (Assistant Administrator in Training) and V4 (Social Services Director). R6 stated, Staff do nothing and (R9) is allowed to come down my hall all of the time. R6 stated sometimes R9 is 1:1 with staff and at other times he's not, especially at night. R6 described how she is afraid to come out of her room, unable to go get ice, and eats meals in her room to hide from R9. R6 stated she is afraid of R9 and R9 makes her feel uncomfortable. R6 stated she is coming back to the facility soon and is very worried about what might happen to her with R9 still in the facility. On 1/25/23 at 12:59 PM, V1 (Administrator in Training) stated R6 came to her with concerns that R9 was getting too close to her. V1 could not recall what day that occurred, but indicated it was recent, within the month. V1 denied knowledge of the 1/05/23 grievance completed by V4 regarding R6 and R9. V2 (Assistant Administrator in Training) was in the office during this interview and denied knowledge of the grievance as well. V1 and V2 denied V4 bringing to the attention of Management that R6 had complaints of R9 touching her sexually during the 1/06/23 morning management meeting. V1 stated, Had I known, I would have reported an allegation of sexual abuse. V1 stated the only thing R6 told her was that (R9) was getting in her personal space, but not that (R9) had physically touched her. V1 stated she did not have any documented evidence of this conversation with R6, or any subsequent actions taken. V1 confirmed that she was in attendance for the Resident Council meeting on 1/10/23. V1 stated she did not interview the four female residents that spoke out about R9's behavior. V1 stated, I recall (R6) speaking out against (R9) and (R10) as well. I do not remember the other two residents having specific concerns with (R9). I can't tell you my exact immediate follow up. I did not interview any residents that had concerns. At some point, I had a conversation with (R6 about R9), but I do not know when and did not document the details. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 2/02/23 at 1:59 pm, a follow up interview was conducted with V4 (Social Service Director) regarding R6's allegation against R9 and the 1/06/23 Morning Meeting with Management. V4 stated it was clearly discussed in that meeting that R9 had increasing behaviors, going in and out of resident rooms at night, and what R6 reported on 1/05/23. V4 stated Management suggested at that R9 go on 1:1 supervision or they find placement for him elsewhere. V4 stated they discussed R9 being placed back on 1:1 supervision so it didn't escalate to a reportable incident. If (V1 and V2) stated they didn't know this, they are lying. On 1/30/23 at 9:17 am, V1 stated in a follow up interview she has still not initiated any kind of formal investigation into the sexual abuse allegations reported to her last week involving R6 and R9. V1 stated she was completely unaware of R9's sexually tendencies until the survey team brought it to her attention last week. V1 stated V31 (Administrator) is still unaware of the allegations of sexual abuse by R9. 2. An official court document, dated 4/10/2017 documents V30 (R6's Mother) and V37 (R6's Father) as being appointed Guardians of the Estate & Person of (R6), a disabled adult, and are authorized to have, under direction of the Court, the care, management, and investment of the ward's estate and the custody of the ward, and to do all acts required by them by law. A Resident Profile Face Sheet documents R6 was admitted to the facility on [DATE]. A Subpart S Eligibility Screening, dated 5/13/22, documents under Section B that R6 has the diagnoses of Schizo-affective Disorder and Bipolar Disorder, and under Section E - (checked for yes) Are impairments in these areas primarily due to the resident's serious mental illness listed in Section B. (Checked for yes) Resident's impairment cannot be primarily due to any of the following (Check box if impairment is due to diagnosis listed): with Mental Retardation circled. Physician's Orders, dated 1/01/23, document R6 has the current diagnoses of Anxiety, Schizoaffective Disorder, Intellectual Disability, and Chronic Post Traumatic Stress Disorder. On 1/31/23 at 1:05 pm, V10 (Ombudsman) stated V30 (R6's Mother) contacted her today, very upset and concerned about R6 being in a sexual relationship with a male resident in the facility. V10 stated V30 discussed this with the Social Services Department in December, but the facility was not doing anything to stop R6 from having sexual intercourse with this resident. V30 stated the concern is that R6 does not have the mental capacity to consent to a sexual relationship with someone. On 1/31/23 at 2:44 pm, V30 stated, Around the beginning of November, (R6) told her me she had been caught having sex with this man (R15), in his room and her room, multiple times, and I'm concerned because I'm (R6's) State appointed guardian and (R6) has the mental capacity of a 10-[AGE] year old. I spoke to (V1) immediately after I found out, and (V1) told me (R6) was a consenting adult and there was nothing they could do about her having sex with this man, who is twice her age. On 2/02/23 at 1:30 pm, V30 stated she reviewed her phone records and she spoke with V1 on 11/08/22 about R6 and R15 having sex. V30 stated V1 told her R6's BIMS (Brief Interview for Mental Status) was too high, and they were able to consent to a sexual relationship. V30 stated she told V1 that she did not agree, as (R6) has the mentality of a teenage girl. On 2/01/23 at 1:17 pm, R6 stated she has sex with R15. R6 stated, (R15) is my boyfriend and we are going to get married. R6 was asked where she has sex with R15 and she stated, Wherever, and Oh we've been caught by people. R6 was asked if she had sex with R15 in his room or hers, and she stated both. R6 was asked what happens when they get caught and R6 stated, They just tell us not to do it again. My Mom knows. I told her. I told her we want to get married. (continued on next page)

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	02/23/2023

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 2/2/23 at 10:00 a.m., R6 stated, We (R6 and R15) have sex. We've tried to have a baby three or four times to get out of here and move to Chicago, but I guess this thing is working (pointing to her birth control implant in her left upper arm). On 2/02/23 at 1:59 pm, V4 (Social Services Director) stated she talked to both R6 and R15's families regarding their sexual relationship in December, but (R6 and R15) had a high enough BIMS, so they could not stop them. V4 stated, (V1) was fully aware (of their sexual relationship); she has talked to (R6 and R15's) family regarding this. V4 stated they did discuss developing a care plan with individualized interventions to keep R6 and R15 from having sexual relations, but that never transpired. On 2/01/23 at 2:33 pm, V14 (Social Service) stated she has heard from multiple staff and residents that R6 and R15 are in a sexual relationship. V14 stated, The first time I heard about them having sex, (R6) was in the hospital. It was a couple of months ago. Since (R6) was in the hospital, it was after the fact, and I did not report it to (V1). V14 stated there was a recent Care Plan meeting with R6's parents, V4 (Social Service Director) and V15 (Social Services). V14 stated, The main topic of that meeting was (R6's) sexual relationship with (R15). On 2/01/23 at 3:55 pm, V1 (Administrator in Training) stated, All I know regarding (R15 and R6) is that (R6) told her Mom that they are getting married, and I have never been told they were in a sexual relationship. V1 stated she would expect staff to tell her if they had knowledge of them being in a sexual relationship. V1 stated she personally does not feel R6 has the mental capacity to consent to a sexual relationship. 3. Resident Council Meeting minutes, dated 1/10/23 document the following concerns: LPN (is) stealing narcotics, CNAs (Certified Nursing Assistants) yelling at residents is not okay and needs to stop, and (CNAs) retaliating with residents when they have an issue with things. A Resident Council Concern Form, completed by V16 (Activities Director) on 1/10/23, documents Department: Administration, under Concern/Complaint it states in the notes section, CNAs and nurses are retaliating when they (residents) bring issues to them that staff does not agree with, and (R2) also brought up LPNs (Licensed Practical Nurses) stealing narcotics. A Resident Council Concern Form, completed by V16 (Activities Director) on 1/18/23, documents Department: CNAs, under Concern/Complaint: Residents believe that the CNAs yelling at residents is not okay, and They are also concerned that the CNAs are retaliating when the residents bring up issues to them that they do not agree with. A Resident Council Concern Form, completed by V16 (Activities Director) on 1/10/23, documents Department: Nursing, under Concern/Complaint: Certain Nurses are retaliating against residents who give them issues. A documented summary of V10's (Ombudsman) notes from the 1/10/23 Resident Council Meeting include the following information: (Nursing Staff) ignore residents when residents need help. One resident stated the less cognitive a resident is the worse it is for them, Residents being forced to stay in their rooms or go to their rooms, It was stated that when (R3) had a fainting episode staff makes fun of him because the staff think he is faking it (V11/Registered Nurse)(is the main one), (R3 stated) backlash is horrible from staff. Nurses get in your face and saying f**k you, you're going to your room. Resident is staying in his room due to being uncomfortable. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 1/26/23 at 8:15 am, V10 (Ombudsman) stated she was present for the 1/10/23 Resident Council Meeting and several residents attended. V10 stated V1 (Administrator in Training) and V2 (Assistant Administrator in Training) were present for the entire meeting. V10 stated R2, who is the Resident Council [NAME] President, was voicing most of the concerns, and R2 even had all his concerns typed up, giving everyone a copy. V10 stated other residents were agreeing with R2's issues brought forth. V10 stated several resident concerns were abusive in nature. V10 stated R2 verbalized he has witnessed nursing staff, specifically V3 (Resident Care Coordinator), take resident medications home with her after she dispenses medication from the pill sleeve. V10 stated multiple residents complained of staff retaliating when they complain about something, staff will be mean to them, make fun of residents, and yell at them. V10 stated she has discussed abuse concerns with V1 before, but she does not act on them. At that time, V10 provided a copy of the typed concerns from R2 that was given to everyone in attendance at the 1/10/23 Resident Council Meeting. R2's documented Grievance List from 1/10/23, provided by V10, documents the following statements: (Licensed Practical Nurse, name withheld) pulls meds, while pulling meds, when she grabs meds out of lock box (for narcotics), she pops all meds into dispensing cup, except the narcotic, it gets popped onto the top of (the medication) cart and slipped into her pocket. On 1/24/23 at 3:45 pm, V16 (Activities Director) was interviewed regarding all the abuse concerns documented from the Resident Council Meeting on 1/10/23. V16 confirmed that V1 and V2 were present for the meeting that day. V16 stated that staff retaliation against residents was mentioned by R2, but he didn't expand on it so she was unaware of what R2 meant specifically. V16 stated it was discussed during the meeting that residents have observed nursing staff popped the narcotic pill out, put it to the side of the medication cart, then slide it into her pocket. V16 recalled R2 stating that if residents do something that the CNAs don't like, they will raise their voices at them. V16 went on to say that she documented all the resident concerns and gave specific concern forms to each Department Head, as well as a copy of the Resident Council Meeting Minutes to V1 (Administrator in Training). (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 1/25/23 at 12:59 pm, V1 (Administrator in Training) confirmed that she was present for the 1/10/23 Resident Council Meeting, and she had received a copy of the 1/10/23 Resident Council Meeting notes. V1 stated, I still want to go through and talk to residents. When I get complaints, I don't always jump. V1 stated, My approach to the wrong medications being given and narcs (narcotics) being stolen was to wait and see how med (medication) pass was going. My thought process is it not over. I'm waiting to sneak up and see what I catch. V1 stated she did complete a Narcotic Count at the medication carts, which was fine. V1 stated she at some point asked V3 (Licensed Practical Nurse/Resident Care Coordinator) if anything had been reported regarding missing narcotics, and the answer was no. V1 stated she did not conduct a full investigation into the misappropriation of resident's narcotics, nor did she report the allegation to the State Agency. V1 stated she just started getting copies of the Resident Council Meeting minutes and she received the copy from the (1/10/23) meeting minutes last week. V1 stated she did read the minutes when she received them and acknowledged There were several serious concerns brought up at the meeting. V1 stated she did not interview any residents that had specific concerns, but she did have a conversation with R6. V1 stated she could not recall any specifics regarding the allegation of CNAs yelling at residents, but I decided to do a broad in-service regarding bedside manner and customer service that day, as it was a scheduled in-service day. V1 did admit that the allegations that came from the Resident Council Meeting could lead to an abusive situation. V1 stated she did ask R16 in that moment during the Resident Council Meeting what staff were yelling at residents and then R16 denied anything occurred. V1 stated she did not interview in private or probe further, with any other residents regarding the concerns. V1 stated, I didn't view the complaints warranted interviewing specific residents in private to determine what CNAs are yelling at residents and what they are yelling at them for. V1 stated she did not interview any staff regarding other staff's behavior. When V1 was questioned about the statement made by R2 that staff are retaliating against them when they complain, V1 stated she talked to my Department Heads and instructed them to do 'Angel Rounds,' inquiring as to if residents have concerns about retaliation. V1 was unable to provide any documentation related to the information gathered during 'Angle Rounds.' V1 stated, she did not recall the word retaliation being used in the Resident Council Meeting but concluded retaliation is concerning. 4. On 1/26/23 at 8:15 am, V10 (Ombudsman) stated 1/19/23, she informed V1 that R3 had reported to her V27 (Licensed Practical Nurse) was hitting him in the leg when she passes medication and that V3 (Licensed Practical Nurse/Resident Care Coordinator) had yelled at R3 a few days prior. V10 said she specifically told V1 that R3 reported to her V3 yelled at him to Shut the f**k up and threatened to call the police on him. V10 stated V1 informed her that she had already spoken to V3 about the situation and that was not what had happened. V10 stated she was concerned that V1 did not report or investigate this a[TRUNCATED]

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33960 Based on observation, interview, and record review, the facility failed to perform a thorough and timely investigation of a fall, complete neurological assessments following a fall with head involvement, implement new fall interventions, and assess a resident post fall to ensure no further injury for three of three residents (R1, R5, R7) reviewed for falls in the sample of 25. Findings include: The facility's Fall Prevention policy, dated 11/10/18, documents, Immediately after any resident fall the unit nurse will assess the resident and provide any care or treatment needed for the resident. A fall huddle will be conducted with staff on duty to help identify circumstances of the event and appropriate interventions. The unity nurse will place documentation of circumstances of a fall in the nurses notes or on an AIM for Wellness form along with any new intervention deemed to be appropriate at the time. Report all falls during morning Quality Assurance meetings Monday through Friday. All falls will be discussed in Morning Quality Assurance meeting and any new interventions will be written on the care plan. The facility's Head Injury policy, dated 12/22/17, documents, It is the policy of the facility to evaluate head injuries for a minimum period of 72 hours, to determine any negative effects, and to allow for immediate treatment to minimize permanent damage. The policy also documents, The following procedure focuses on proper assessment of residents who have sustained a head trauma. Determine if resident is on anti-coagulant or any medication that lends itself to the thinning of the blood. If a resident is on such medication they are to be sent out for evaluation. Ongoing assessment (vital signs and neurological checks) should take place as follows: Initially and every 15 minutes for one hour; Every 30 minutes for one hour; Every hour for four hours; Every four hours for 8 hours; Every shift for the remainder of 72 hours. 1. R1's Nurses' notes, dated 10/6/22 at 8:30 a.m., document, R1 found sitting on the floor in her room at this time. Unable to voice what happened but another resident reports that she saw her fall. Both witness and R1 report R1 did not hit her head. R1's nurses' notes have an entry on 10/6/22 at 5:00 p.m. and 10/7/22 at 5:00 a.m. However, no vital signs are documented in those entries. Also, there is no documentation of any type of assessment following R1's fall. The next documented entry in R1's nurses' notes is 10/14/22 at 6:00 p.m. R1's Quality Care Reporting Form, dated 10/6/22 at 8:30 a.m., documents that R1 had a fall in her room, and she has no injuries but complains of pain everywhere. The form also documents that the investigation was not completed until 1/3/23 and the new intervention was for R1 to be on 15 minute visual checks. R1's 15 minute visual checks, dated 10/1-10/6/22, document that R1 was on 15 minute visual checks prior to R1's incident on 10/6/22. (continued on next page)

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	146097	A. Building B. Wing	02/23/2023

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Nurses' notes, dated 11/19/22 at 1:30 p.m., document, R1 found on floor on right side in doorway. Wheelchair at feet with trash in seat. R1 denies injury but states did bump head on floor. No redness, bumps or bruises. R1 states had been taking trash to trash can and was pushing wheelchair when she fell . R1's nurses' notes have an entry at 4:00 p.m. on 11/19/22. However, no vital signs are documented in this entry nor is there any documentation of any type of assessment following R1's fall. The next documented entry in R1's nurses' notes is 11/24/22. R1's Neuro/Head Trauma Assessment, dated 11/19/22, documents, Record vital signs in appropriate box. Place NA (not applicable) in the box if the resident does not exhibit the symptoms. Place an X in each box for each symptom found. Notify the physician if any abnormal results are found. Assess as follows: a) initially and every 15 minutes times four; b) every 30 minutes times one hour; c) every one hour times four hours; d) every four hours times eight hours; and e) every shift for remainder of 72 hours. The Assessment has no documentation of R1 being assessed for the every four hours for eight hours nor for the every shift assessment. R1's Nurse's notes, dated 12/29/22 at 9:30 p.m., document, R1 found on floor in room. Laying on right side hanging onto bed rail. Legs bent. Moderate amount of blood coming from nares. Nose is red and swollen. Resident sent to emergency department for evaluation. R1's Hospital After Visit Summary, dated 12/30/22 at 6:56 a.m., documents, Diagnoses: Contusion of nose. R1's Neuro/Head Trauma Assessment, dated 12/29/22, documents that R1 had a neurological assessment initially at 9:20 p.m. then R1 was at the hospital for the every 15 minute checks x 4, every 30 minute checks x 2, every hour checks x 4 and the first every four hour check. There is no documentation of any further neurological checks being done from the second every four hour check x 2 nor the every shift assessment x 7. R1's Quality Care Reporting Form, dated 12/29/22 at 9:20 p.m., documents that R1 had a fall in her room, and she has an injury to her nose that is red, swollen, and bleeding. The reporting form also documents that the new intervention to prevent further falls is a medication review by R1's physician, and that the investigation for this fall was not completed until 1/3/23. R1's Nurses' notes, dated 12/29/22 to 1/16/23, have no documentation of R1's return from the hospital on 12/29/22 nor the three day post fall monitoring every shift. R1's Quality Improvement Review documents, 1/3/23: QA (Quality Assurance) meeting related to review of fall on 10/6/22. As root cause up with no assistance. No injury. Intervention resident will be placed on 15 minute visual checks; 1/3/23: QA meeting related to review of fall on 12/29/22 with root cause of resident up with no assistance with contusion to nose. Nursing intervention for resident's medication to be reviewed by physician. On 2/2/23 at 9:30 a.m., the facility was unable to provide documentation of a medication review being completed for R1 by a physician. V1 (Administrator in Training) confirmed that there is no medication review for R1. (continued on next page)

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	146097	A. Building B. Wing	02/23/2023

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/2/23 at 2:50 p.m., V47 (MDS/Minimum Data Set) Coordinator) stated, R1's care plan was not updated for her falls on 10/6/22, 11/19/22, and 12/29/22 until 1/3/23. V47 also confirmed that (R1's) neurological assessments were missing assessments. On 2/2/23 at 4:00 p.m., V6 (Certified Nursing Assistant/CNA) confirmed that R1 was on 15 minute checks prior to 10/6. 2. On 1/24/23 at 11:50 a.m., R5 was alert but nonverbal sitting up on the side of her bed. R5 sits up and then lies down with almost constant spastic movements. R5 had a purple and yellow bruise with swelling to the outer corner of R5's right eye. R5's Nurses' notes, dated 10/3/22 at 11:30 a.m. document, R5 was observed standing at nurses' station. Resident backed up over another resident wheelchair foot pedal and fell . R5's Quality Care Reporting form, dated 10/3/22 at 11:10 a.m., documents that R5 had a fall at the nurses' station. The form has no documentation of V44 (R5's Power of Attorney) being notified. The form also documents that the investigation for this fall as not completed until 11/7/22. R5's Nurses' notes, dated 10/27/22 but no time, documents, R5 had fall today. Reported by staff and other resident. R5's Quality Care Reporting form, dated 10/27/22 at 12:30 a.m., documents that R5 had a fall in R5's room. The form also documents that the investigation for this fall as not completed until 11/7/22 with an intervention for PT (Physical therapy)/OT (Occupational therapy) to evaluate R5. R5's Nurses' notes, dated 12/9/22 at 8:00 a.m., document, R5 was in dining room and went to sit in chair, sitting too hard on one side causing R5 to fall with chair coming on top of her. Bruising and skin tear noted to right hand. R5's Quality Care Reporting form, dated 12/9/22 at 8:00 a.m., documents that R5 had a fall in the facility dining room. The form also documents that the investigation for this fall as not completed until 12/22/22 with an intervention for R5 to have 1:1 supervision. R5's Quality Improvement Review documents, 11/7/22: QA team met for R5 fall on 10/13/22 at 11:10 a.m. R5 tripped over wheelchair. No injury noted. Educated staff on putting all equipment on one side of hallway for clearer paths. 11/7/22: QA team met for R5 fall on 10/27/22. R5 lost balance. No injury noted. Refer to PT/OT for further evaluation. R5's Resident Monitoring One to One, dated 12/31/22, documents that R5 was on 1:1 supervision on this date. R5's Current medical record has no documentation of R5 receiving a PT/OT evaluation from 10/22 to 1/23 nor any other 1:1 monitoring from 12/9-12/30/22. On 2/2/23 at 2:50 p.m., V47 (Minimum Data Set Coordinator) stated, (R5) was not on 1:1 until at least 12/31. The 1:1 for 12/31 was the only 1:1 for the month of December that was in her chart. There is no physical or occupational therapy evaluations in her chart from October to now. V47 also confirmed that (R5's) care plan was not updated with fall interventions. (continued on next page)

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	146097	A. Building B. Wing	02/23/2023

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. On 2/1/23 at 1:20 p.m., R7 was alert walking around in his room. R7's right hand had yellow fading bruising to his middle and ring finger. R7 stated, I got mad and punched the door. I shouldn't have done that, and I know better. R7's Nurses notes, dated 10/26/22 at 7:00 a.m., document, R7 reported hitting head on nightstand while backing over to plug something in. No discoloration noted. R7 on Coumadin. Neuro checks initiated. R7's Neuro/Head Trauma Assessment, dated 10/26/22, documents that R7's neurological assessment was not completed on four of the seven shifts for every shift assessments. R7's medical record has no documentation of R7 being sent to the ER after hitting is head as a result of an incident. R7's Quality Care Reporting form, dated 10/26/23 then marked over to be dated 10/26/22 at 7:00 a.m., documents that R7 had an incident in his room. The form also documents, Pain location: Tenderness to area on hand. The form has no signature as to who completed this form, and its dated as being completed on 2/2/23. Also, the investigation portion of the form is blank as well as no new intervention to be implemented to prevent further incidents. R7's Nurses' notes, dated 1/5/23 at 9:50 a.m., document, R7 got up from bed, states he became dizzy causing him to fall falling backwards. Denies pain. Sent to emergency room for evaluation. R7's Quality Care Reporting Form, dated 1/5/23, documents that R7 had a fall on 1/5/23 at 9:40 a.m. in his room, and was sent to the ER. The form also documents the investigation was not completed until 1/9/23. R7's Physician's orders, dated 1/23, document an order received on 1/23/23 to x-ray R7's right hand due to pain and swelling. R7's X-ray report, dated 1/23/23, documents, Impression: The appearance of deformity of the distal aspect of the 5th metacarpal suggestive of acute fracture. R7's Nurses' notes nor rest of current medical record have any documentation of what occurred in order for the physician to order an x-ray for R7's right hand. Then, following the results there was no investigation completed nor follow up documentation. As of 1/25/23, the last Nurses' notes entry was 1/5/23. R7's care plan, dated 5/14/20, has no documentation of any revision following R7's incidents on 10/26/22 and 1/23/23. On 2/2/23 at 2:50 p.m., V47 confirmed R7's care plan was not updated following his incidents. On 2/2/23 at 3:30 p.m., V1 (Administrator in Training) and V31 (Vice President of Business Development and Strategy/Regional Director of Operations) confirmed that R7's Incident investigation was dated 2/2/23 and 10/26/22 and that there was not two separate investigations for each incident (10/26/22 and 1/12/23). They also confirmed that incidents when a resident hits their head require neurological checks, and sent to ER if on Coumadin, but (R7) was not sent to theER on [DATE]. (continued on next page)

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	146097	A. Building B. Wing	02/23/2023

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/2/23 at 9:30 a.m., V1 stated, After a fall a resident should be charted on for 3 days every shift.

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	02/23/2023

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 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33960 Based on observation, interview, and record review, the facility failed to ensure a resident (R20), who is non-verbal, received gastrostomy tube (g-tube) feedings for adequate nutritional intake as ordered by the physician, implement dietician recommendations to prevent further weight loss, obtain daily weights, and document dietary meal intakes to prevent significant weight loss for three of four residents (R1, R5, R20) reviewed for weight loss in the sample of 25. As a result of this failure R20 went nine days without receiving any type of nutritional intake causing her emotional/psychological distress as well as pain related to hunger pains. R20 has also lost 20 lbs (11.4% weight loss) since R20 was admitted on [DATE] (five months). These failures resulted in an Immediate Jeopardy. While the immediacy was removed on 2/23/23, the facility remained out of compliance at a Severity Level 2. The facility is ensuring all in-house licensed staff and QAT (Quality Assurance Team) members are educated on administering g-tube feedings, processing physician's orders, notifying the physician of dietician recommendations and a resident not receiving scheduled g-tube feedings. The facility is also ensuring that all licensed staff are educated on who to contact when needing g-tube feeding equipment that is not available within the facility, g-tube feeding pump safety, procedures during an emergency with a g-tube, and proper handling of g-tube equipment. Also, the facility is reviewing all of the residents for weight loss to ensure the physician and dietician were notified of any significant weight losses. As well as developing a system to audit the g-tube feeding formulas ordered and used. Findings include: The facility's Resident Weight Monitoring policy, dated 9/08, documents, If there is an actual significant weight change, the resident, family/guardian, physician, and dietitian are notified. The date of notification for physician and family/guardian is documented on the Report of Monthly Weight form. The Food Service Manager and/or dietician reviews the resident's nutritional status and makes recommendations for intervention in the nutrition progress notes. The Food Service Manager and/or dietitian notify nursing of any recommendations that have been documented. Nursing then contacts the physician to convey recommendations and obtain any new orders. Significant unplanned weight changes are reviewed in the weekly Weight Committee Meeting. The Weight Committee will also identify any gradual weight loss or gain trends. Significant changes in weights are documented in the care plan with goals and approaches/interventions listed. The facility's Therapeutic & Mechanically Altered Diets policy, dated 4/06, documents, It is the policy of the facility that therapeutic and mechanically altered diets are ordered by the physician and planned by the dietician. A therapeutic diet is a diet ordered to manage problematic health conditions. Examples include caloric specific, low-salt, low-fat, low lactose, no sugar added, and supplements during meals. The policy also documents, A physician's order is written for all diets including therapeutic and mechanically altered diets. All physician ordered diets are planned in writing. Portion sizes are evident for each item on the menu extensions. The facility prepares and serves all therapeutic and mechanically altered diets as planned. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's Enteral Tube Feeding Bolus Procedure policy, no date available, documents, It is the policy of the Facility to provide nutrition via Nasogastric or Gastrostomy tubes when ordered by physician. The resident may receive nutrition and hydration either by intermittent, continuous, or bolus feeding into the stomach by means of a tube when the oral route cannot be used. The policy also documents, Report unusual observations/findings to the physician. Report observations regarding feeding tolerance to the dietician. Document information related to feeding on flow record and/or TAR (Treatment Administration Record)/MAR (Medication Administration Record). 1. On 2/6/23 at 2:00 p.m., R20 was lying in her bed on her right side with her eyes open. When spoken to she lifted her head, made eye contact and laid back down without responding. On 2/6/23 at 3:30 p.m., R20 was partially sitting up in bed with a flat affect and no verbalization. Questions asked to R20. R20 did not respond verbally. However, did respond at times with a thumbs up or thumbs down partially, but it was hard to understand her response. R20 became frustrated and laid back down facing the wall. R20's Report of Monthly Weights and Vitals, dated 2022, documents R20's Admission weight on 8/6/22 was 176 lbs (pounds). R20's Physician's orders, dated 8/22, documents that R20 was admitted on [DATE] with an order to receive Jevity 1.2 237 ml (milliliters) via gastrostomy tube every three hours. R20's Dietitian Nutritional Assessment, dated 8/19/22, documents, (R20) admitted on regular finger food diet with thin liquids and chopped meats. Tube feeding order of Jevity 1.2 237 ml via gastrostomy tube every three hours for 24 hours if (R20) eats less than 50%. 60 ml FWF (Free water flush) before and after feedings. Tube feeding order provides 2275 kcals/day, 105 g (grams) protein/day and 1530 FW/day. FWF provides 960 ml FW (Free Water)/day. No intakes available for review at this time. CBW (Current Body Weight) 176 lbs. Weight trending down since admission. (R20's) meeting estimated fluid and kcal requirements with current tube feed order. Tube feed order provides above protein needs. Nurse reports encouraging resident to eat without success. (R20) is eating 0%. Tube feeding order fully utilized due to 0% intakes. Continuous feed not appropriate at this time due to (R20) attempts to elope. Recommend weekly weights. Monitor weight, intake, medications, labs, skin integrity, tube feeding tolerance. R20's Dietary Services Communication, dated 8/22/22, documents, Observations: Tube feeding to hold if GRV (Gastric Residual Volume) is greater than 100 ml. Aspen Guidelines state hold if tube feeding GRV is greater than 500 ml. Dietary Recommendations: Recommend discontinue current GRV order. Recommend hold tube feeding if GRV is greater than 500 ml. Recommend weekly weights. The communication also documents that R20's physician acknowledged and approved the recommendation. R20's MAR (Medication Administration Record), dated 8/6-8/30/22, documents that R20 is to receive Jevity 1. 2 237 ml via gastrostomy tube every three hours, and there is no documentation that R20 received the Jevity bolus on the following dates/times: 8/7 - 6:00 p.m., 3:00 a.m.; 8/8 - 6:00 p.m., 3:00 a.m.; 8/9 - 3:00 a.m.; 8/10 - 6:00 p.m., 9:00 p.m., 3:00 a.m.; 8/11 - 6:00 a.m., 9:00 p.m., 12:00 a.m., 3:00 a.m.; 8/12 - 3:00 p.m., 6:00 p. m., 12:00 a.m., 3:00 a.m.; 8/13 - 3:00 a.m.; 8/14 - 6:00 a.m., 12:00 p.m., 12:00 a.m., 3:00 a.m.; 8/15 - 6:00 a. m.; 8/16 - 12:00 a.m., 3:00 a.m.; 8/18 - 9:00 p.m.; 8/19 - 6:00 a.m., 12:00 a.m., 3:00 a.m.; 8/20 - 6:00 p.m.; 8/22 - 9:00 p.m.; 8/25 - 9:00 a.m., 3:00 p.m., 6:00 p.m. 9:00 p.m.; 8/30 - 6:00 p.m.; 8/31 - 9:00 p.m. for a total of 36. (continued on next page)

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	146097	A. Building B. Wing	02/23/2023

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R20's TAR (Treatment Administration Record), dated 8/6/22-8/31/22, documents that R20 is to be a daily weight. However, during the time span of 8/6-8/31 only one weight was obtained on 8/29/22. R20's Report of Monthly Weights and Vitals, dated 2022, documents R20's 9/22 weight was 170 lbs (6 lbs 3. 4% weight loss in one month). R20's Dietary Notes, dated 9/21/22 and signed by V40 (Registered Dietician), document, CBW 170 lbs. Gradual weight loss since admission. Regular pureed diet with thin liquids. 0% intakes recorded for three meals. Tube feeding order of Jevity 1.2 237 ml via gastrostomy tube every three hours for twenty four hours if less than 50% intakes. 60 ml FWF plus tube feeding order plus FW provides 2275 kcals/day, 105 g protein/day, 2490 FW a day. R20 meeting estimated kcal and fluid requirements with current tube feeding order. R20 tolerating tube feedings per nursing notes. Nurse reports R20 drinks but does not eat anything as per above. V40 recommendations for GRV signed last month; per nurse. Tube feeding not be held due to GRVs. Continuous feed would be appropriate overnight due to R20 receives 1:1 care. Continuous feed may assist with weight control. Recommend Jevity 1.2 at 150 ml/hour for twelve hours overnight with 200 ml FWF three times a day during feedings. Tube feeding provides 1800 ml volume/day, 2160 kcals/day, 99.9 g protein per day, 1453 FW per day. 200 ml FWF three times a day provides 600 ml FW per day. New tube feeding recommendations meet estimated nutrient needs. Monitor weight intake, medications, labs, skin integrity, tube feeding tolerance, tube feeding order. R20's Dietary Services Communication, dated 9/21/22 and signed by V40, documents, Observations: Nurse requests continuous feed for tube feeding. Gradual weight loss. Recommendations: Recommend Jevity 1.2 at 150 ml/hr for 12 hours overnight with 200 ml FWF three times a day during feedings. The communication also documents that the physician acknowledged and approved the recommendation on 10/20/22. R20's current medical record has no documentation of V40's 9/21/22 recommendation being followed through with until signed by the physician on 10/20/22. R20's MAR, dated 9/22, documents that R20 is to receive Jevity 1.2 237 ml via gastrostomy tube every three hours, and there is no documentation that R20 received the Jevity bolus on the following dates/times: 9/1 - 6:00 p.m.; 9/6 - 6:00 p.m., 9:00 p.m.; 9/7 - 6:00 a.m., 9:00 a.m., 12:00 p.m., 3:00 p.m., 6:00 p.m., 12:00 a.m., 3:00 a.m.; 9/8 - 9:00 p.m.; 9/10 - 9:00 p.m.; 9/11 - 12:00 a.m., 3:00 a.m.; 9/12 - 6:00 a.m., 12:00 a.m., 3:00 a. m.; 9/14 - 9:00 p.m.; 9/19 - 6:00 p.m.; 9/20 - 6:00 p.m., 9:00 p.m.; 9/21 - 6:00 a.m., 9:00 a.m., 12:00 p.m., 3:00 p.m., 12:00 a.m., 3:00 a.m.; 9/22 - 6:00 p.m.; 9/23 - 6:00 p.m.; 9/24 - 6:00 p.m.; 9/25 - 6:00 p.m., 9:00 p. m.; 9/26 - 12:00 a.m., 3:00 a.m.; 9/27 - 6:00 p.m.; 9/28 - 6:00 p.m.; 9/29 - 6:00 a.m., 12:00 a.m., 3:00 a.m.; 9/30 - 6:00 a.m. for a total of 40. R20's TAR, dated 9/22, documents that R20 is to be weighed daily as of 9/6/22 and there is no documentation of a weight being obtained on the following dates: 9/7, 9/15-9/17, 9/19-9/25, 9/29-9/30. (continued on next page)

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	146097	A. Building B. Wing	02/23/2023

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R20's Food & Fluid Intake Sheet, 9/22, documents that R20 refused the following meals: 9/23 lunch, 9/24 breakfast & lunch, 9/26 breakfast, 9/30 breakfast & lunch. The sheet also zero documented for intake on the following meals: 9/1-9/2 all three meals, 9/4 all three meals, 9/6-9/7 all three meals, 9/8 supper, 9/10 all three meals, 9/14 supper, 9/15-9/16 all three meals, 9/25 lunch, and it has no documentation for R20's intakes on the following days: 9/3 all three meals, 9/5 all three meals, 9/8 breakfast & lunch, 9/9 all three meals, 9/11-9/13 all three meals, 9/14 breakfast & lunch, 9/17-9/19 all three meals, 9/20 breakfast & lunch, 9/21-9/22 all three meals, 9/23 breakfast & supper, 9/24 supper, 9/26 supper, 9/27-9/29 all three meals, and 9/30 supper. R20's Nurses' notes, dated 9/27/22 at 12:00 p.m., document, R20 continues to yell out and it is very difficult to understand her needs. Seems to be in pain. This date is also date in which there is no documentation of R20 receiving a scheduled g-tube bolus. R20's Report of Monthly Weights and Vitals, dated 2022, documents R20's 10/22 weight was 160 lbs (10 lbs 5.9% weight loss in one month). R20's Dietary notes, dated 10/18/22 and signed by V40, document, CBW 163 lbs. Gradual weight loss for 30 days noted. Tube feeding order of Jevity 1.2 237 ml via gastrostomy tube every three hours for twenty four hours if less than 50% intakes. Tube feeding order plus FW provides 2275 kcals/day, 105 g protein/day, 2490 FW a day. R20 meeting estimated kcal requirements; however, receiving above protein and fluid requirements with current tube feeding order. Extra protein may be appropriate due to failure to thrive diagnosis and continued weight loss. 0% PO (by mouth) intakes recorded for three meals. V28 (Dietary Manager) confirms little to no intakes as per above. Continuous feed may assist with weight control as per previous. Recommend Jevity 1.2 at 150 ml/hour for twelve hours overnight with 200 ml FWF three times a day during feedings and 30 ml FWF twice a day before and after medications. New tube feed order provides 1800 ml volume/day. 2160 kcals/day, 99.9 g protein/day, 1453 ml FW/day. New tube feed order meets estimated nutrient needs. R20's Dietary Services Communication, dated 10/18/22 and signed by V40, documents, Observation: Gradual weight loss for 30 days. Tube feed bolus. Recommendations: Recommend Jevity 1.2 at 150 ml/hr for 12 hours overnight with 200 ml FWF three times a day during feedings and 30 ml FWF twice a day before and after medications. The communication also documents that the doctor acknowledged and approved the recommendation on 10/20/22. R20's Physician's orders, dated 10/22, document that R20 received an order on 10/20/22 for Jevity 1.2 at 150 ml/hr for 12 hours overnight with a 200 ml flush three times during feedings and a 30 ml flush twice a day before and after medications. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R20's MAR, dated 10/22, has no documentation of R20 receiving her Jevity 1.2 237 ml every three hour bolus on the following dates/times: 10/1 - 3:00 p.m., 3:00 a.m.; 10/6 - 9:00 p.m.; 10/7 - 6:00 p.m.; 10/9 - 9:00 p.m.; 10/12 - 9:00 p.m.; 10/13 - 9:00 p.m., 12:00 a.m.; 10/16 - 9:00 p.m.; 10/17 - 6:00 p.m., 12:00 a.m., 3:00 a.m.; 10/27 - 12:00 a.m., 3:00 a.m.; 10/28 - 9:00 p.m., 10/29 - 9:00 p.m.; 10/30 - 12:00 p.m., 9:00 p.m.; 10/31 - 9:00 p.m. for a total 19. R20's MAR also documents that R20's order to receive Jevity 1.2 at 150 ml/hr overnight with 200 ml FWF three times a day during feedings was not started until 10/27/22 and there is no documentation of R20 receiving the overnight feeding on 10/29 or 10/30. The as needed medication information page of R20's MAR also documents that R20 received as needed Tramadol 50 mg for yelling out/symptoms of pain twice on 10/9, 10/17, 10/27, 10/29, and 10/30 which were also days that R20 has no documentation of receiving scheduled g-tube boluses. R20's Food & Fluid Intake Sheet, 10/22, documents that R20 had zero for intake on the following meals: 10/1-10/5 all three meals, 10/6 breakfast & lunch, 10/9-10/10 all three meals, 10/11 supper, 10/13 all three meals, 10/15 breakfast, 10/17 all three meals, 10/20 supper, 10/21-10/22 all three meals, 10/25 supper, 10/28 breakfast, 10/29 breakfast & lunch, 10/30 supper, 10/31 breakfast & lunch, and it has no documentation for R20's intakes on the following days: 10/6 supper, 10/7-10/8 all three meals, 10/11 breakfast & lunch, 10/12 all three meals, 10/14-10/15 lunch & supper, 10/16 all three meals, 10/18-10/19 all three meals, 10/20 breakfast & lunch, 10/23-10/24 all three meals, 10/25 breakfast & lunch, 10/26-10/27 all three meals, 10/28 lunch & supper, 10/29 supper, 10/30 breakfast & lunch, 10/31 supper. R20's Report of Monthly Weights and Vitals, dated 2022, documents R20's 11/22 weight was 161 lbs (15 lbs 8.5% weight loss in three months). R20's MAR (Medication Administration Record), dated 11/22, documents that R20 was to receive Jevity 1.2 for twelve hours overnight at a rate of 150 ml/hr being turned on at 8:00 p.m. and turned off at 8:00 a.m. The MAR has no documentation of R20 being administered the feeding on 11/3, 11/5, 11/6, and 11/9 as well as 11/1, 11/2, 11/7, 11/8 were circled as R20's tube feeding was not administered. In the same section that this tube feeding is signed off is a handwritten statement, On hold; pending discontinue - R20 doesn't remain still. The MAR documents that R20 was restarted on Jevity 1.5 237 ml bolus every three hours on 11/9 at 12:00 p. m. There is no documentation of R20 receiving the bolus on the following dates/times: 11/9 - 12:00 a.m. & 3:00 a.m.; 11/10 - 12:00 p.m., 3:00 p.m., 6:00 p.m., 9:00 p.m.; 11/12 - 9:00 p.m.; 11/13 - 3:00 p.m., 6:00 p.m. , 9:00 p.m.; 11/14 - 12:00 a.m., 3:00 a.m.; 11/15 - 9:00 p.m., 11/16 - 6:00 a.m., 12:00 a.m., 3:00 a.m., 11/17 - 6:00 p.m.; 11/18 - 6:00 a.m., 6:00 p.m.; 11/19 - 6:00 p.m., 9:00 p.m., 12:00 a.m., 3:00 a.m.; 11/20 - 6:00 p.m. ; 11/21 - 6:00 p.m.; 11/22 - 6:00 a.m.; 11/24 - 6:00 a.m., 12:00 p.m., 3:00 p.m., 6:00 p.m., 9:00 p.m.; 11/25 - 6:00 a.m., 9:00 a.m., 12:00 p.m., 3:00 p.m., 6:00 p.m.; 11/26 - 3:00 p.m.; 11/27 - 6:00 a.m., 6:00 p.m.; 11/29 - 3:00 p.m., 6:00 p.m. for a total of 41. The as needed medication information page of R20's MAR also documents that R20 received as needed Tramadol 50 mg twice on 11/5, twice on 11/6, and once on 11/9 for yelling out/symptoms of pain which were also days that R20 has no documentation of receiving any type of g-tube feeding. R20 also received the as needed Tramadol on 11/18, twice on 11/19, twice on 11/20, and on 11/25 which were days that R20 has no documentation of receiving scheduled g-tube boluses. R20's Psychiatric Nurse Practitioner Progress note, dated 11/8/22, documents, Assessment & Plan: Anorexia. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R20's Physician notification form, dated 11/9/22, documents, R20 has gastrostomy tube and was ordered for 12 hour of Jevity 1.2 at 50 ml/hr. R20 does not remain still and is constantly getting up and walking halls. Unsafe to be hooked to machine for any length of time. Please consider returning to bolus feeds of Jevity 1.5 237 ml every three hours. The form also documents the physician's order to refer to dietician for orders. R20's current medical record has no documentation of V40 being notified regarding R20's continuous tube feeding being discontinued and boluses started. R20's Dietary Notes, dated 11/16/22 and signed by V40, document, CBW 161 lbs. Significant weight loss noted: 8.5% in 90 days. Tube feeding order of Jevity 1.2 237 ml bolus every three hours via gastrostomy tube with 60 ml FWF before and after feedings and 30 ml FWF twice a day before and after medications. Resident meeting estimated kcal and protein needs with current tube feeding order. Resident receiving above estimated fluid needs. Nurse reports continuous feed discontinued due to resident does not stay in bed for long periods of time throughout the night. Per nurse resident is tolerating feeds at this time. Recommend decrease flushes to 40 ml before and after feedings to provide 2290 ml FW/day. Meeting estimated fluid needs. Recommend 60 ml high calorie supplement twice a day by mouth to assist with weight control. R20's Physician's orders nor MAR, dated 11/22, have any documentation of V40's 11/16/22 recommendation being followed through with. R20's Food & Fluid Intake Sheet, 11/22, documents that R20 refused the following meals: 11/3 all three meals, 11/4-11/5 breakfast & lunch, 11/7 breakfast & lunch, 11/8 supper, 11/9 all three meals, 11/10-11/12 breakfast & lunch, 11/19 all three meals, 11/24 all three meals, 11/26 breakfast & lunch, 11/28 breakfast & lunch, and 11/29 supper. The sheet also has no documentation for R20's intakes on the following days: 11/1 breakfast & lunch, 11/2 all three meals, 11/4-11/5 supper, 11/6 all three meals, 11/7 supper, 11/8 breakfast & lunch, 11/10-11/12 supper, 11/13-11/18 all three meals, 11/22-11/23 all three meals, 11/25 all three meals, 11/23 supper, 11/27 all three meals, 11/28 supper, 11/29 breakfast & lunch, and 11/30 all three meals. R20's Behavior tracking, no date available however V1 verified on 2/16/23 this was R20's 11/22 behavior tracking, documents that R20's target behavior is Inappropriate Behavior. The tracking also documents that R20 exhibited this behavior continuously on 1st shift of 11/5-11/8, 11/12, 11/14-11/15, and 11/19-11/21. 11/5-11/8/22 were four days that the facility has no documentation of R20 receiving any type of g-tube feeding. There is also no documentation of R20 receiving scheduled bolus doses on 11/14, 11/15, 11/19 and 11/20/22. R20's Report of Monthly Weights and Vitals, dated 2022, documents R20's 12/22 weight was 157 lbs (4 lbs in one month, 13 lbs 7.6% weight loss in three months). (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R20's Dietary notes, dated 12/13/22 and signed by V40, documents, CBW 157 lbs. Significant weight loss noted: 7.65% in 90 days. Weight trending down in 30 days. Refusals documented for three meals. Tube feeding order of Jevity 1.2 237 ml bolus every three hours via gastrostomy tube with 60 ml FWF before and after feedings and 30 ml FWF twice a day before and after medications. Resident meeting estimated kcal and protein requirements with current tube feeding order. Recommend: 90 ml high calorie supplement twice a day due to continued weight loss. Discussed continued weight loss with Director of Nursing who would like to trial bolus feeds four times a day. Recommend Jevity 1.2 474 ml bolus four times a day with 40 ml FWF before and after feedings and 30 ml FWF twice a day before and after medications. Meets estimated nutrient needs. R20's Dietary Services Communication, dated 12/14/22 and signed by V40, documents, Observations: Tube feeding. 7.65% weight loss in 90 days. Recommendations: Jevity 1.2 474 ml bolus four times a day with 40 ml FWF before and after feedings and 30 ml FWF before and after medications. 90 ml high calorie supplement twice a day. The communication also documents that R20's physician acknowledged and approved the recommendation. R20's MAR, dated 12/22, has no documentation of R20 receiving her Jevity 1.5 237 ml every three hour bolus on the following dates/times: 12/3 - 6:00 a.m., 6:00 p.m.; 12/4 - 3:00 p.m., 6:00 p.m.; 12/7 - 9:00 p.m.; 12/13 12:00 a.m., 3:00 a.m.; 12/17 - 6:00 a.m., 6:00 p.m., 9:00 p.m.; 12/19 - 6:00 p.m.; 12/21 - 6:00 p.m., 9:00 p.m.; 12/22 - 9:00 p.m.; 12/26 - 3:00 p.m. for a total of 15. R20's MAR also has no documentation of R20 receiving 60 ml of high calorie supplement twice a day nor the 12/13/22 recommendations of 90 ml of high calorie supplement twice a day due to continued weight loss. The as needed medication information page of R20's MAR also documents that R20 received as needed Tramadol 50 mg twice on 11/5, twice on 11/6, and once on 11/9 for yelling out/symptoms of pain which were also days that R20 has no documentation of receiving any type of g-tube feeding. R20 also received the as needed Tramadol on 11/18, twice on 11/19, twice on 11/20, and on 11/25 which were days that R20 has no documentation of receiving scheduled g-tube boluses. R20's TAR, dated 12/22, documents that R20 should be daily weights, however there is no documentation of any weights obtained for the month of December. R20's Food & Fluid Intake Sheet, 12/22, documents that R20 refused the following meals: 12/1-12/2 all three meals, 12/3 supper, 12/4 breakfast & lunch, 12/5 all three meals, 12/6 breakfast & lunch, 12/17 breakfast & lunch, 12/18 all three meals, 12/19-12/20 breakfast & lunch, 12/22 breakfast & lunch, 12/27 breakfast, 12/20 breakfast & lunch, 12/31 all three meals. The sheet also has no documentation for R20's intakes on the following days: 12/3 lunch, 12/4 supper, 12/6 supper, 12/7-12/10 all three meals, 12/11 supper, 12/12-12/13 all three meals, 12/14 lunch & supper, 12/15 all three meals, 12/16-12/17 supper, 12/19-12/20 supper, 12/21 all three meals, 12/22 supper, 12/23-12/26 all three meals, 12/27 lunch & supper, 12/28-12/29 all three meals, and 12/31 supper. R20's TAR, dated 1/23, documents that R20 is to be weighed on a daily basis, however no weights are documented for 1/1-1/4. R20's most recent weight documented was 156 lbs (weight loss of 11.4% since admission-five months) on 1/19/23, and then this order was discontinued on 1/20/23. R20's Dietary Services Communication, dated 1/19/23 and signed by V40, documents, Observation: Tube feeding assessment. Dietary recommendations: Jevity 1.5 375 ml bolus four times a day with 90 ml FWF before and after feedings and 30 ml FWF before and after medications. The communication also documents that R20's physician acknowledged and approved the recommendation on 1/20/23. (continued on next page)

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	02/23/2023

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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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R20's MAR, dated 1/23, documents from 1/7-1/20 R20 had an order to receive Jevity 1.2 474 ml bolus four times a day, and there is no documentation of R20 receiving the bolus on 1/11 at 6:00 a.m. and 12:00 a.m. The MAR also documents that this order was discontinued on 1/20/23 and Jevity 1.5 375 ml bolus four times a day was started. There is no documentation of R20 receiving that bolus on 1/21 at 6:00 p.m. or 1/30 at 12:00 p.m. Also, R20's dietician recommendation to initiate 90 ml of high calorie supplement twice a day was started on 1/7/23, however it was discontinued on 1/20/23. R20's Medical record has no documentation of an order to discontinue R20's 90 ml of high calorie supplement twice a day on 1/20/23. R20's Food & Fluid Intake Sheet, 1/23, documents that R20 refused the following meals: 1/1 all three meals, 1/2 breakfast & lunch, 1/3 all three meals, 1/5 breakfast & lunch, 1/6 lunch, 1/7-1/8 supper, 1/9 all three meals, 1/10 breakfast, 1/11 breakfast & supper, 1/12 breakfast, 1/13 all three meals, 1/14-1/15 breakfast, 1/16 breakfast & lunch, 1/17-1/19 breakfast, 1/20 all three meals, 1/21 breakfast & lunch, 1/22 breakfast, 1/23 breakfast & lunch, 1/24 breakfast, 1/25 all three meals, 1/27-1/29 breakfast & lunch, 1/30 all three meals, 1/31 breakfast. The sheet also has no documentation for R20's intakes on the following days: 1//2 supper, 1/4 all three meals, 1/5 supper, 1/6 breakfast & supper, 1/7-1/8 breakfast & lunch, 1/10 lunch & supper, 1/12 lunch & supper, 1/14-1/15 lunch & supper, 1/16 supper, 1/17-19 lunch and supper, 1/21 supper, 1/22 lunch & supper, 1/23 supper, 1/24 lunch & supper, 1/26 all three meals, 1/27-1/29 supper, and 1/31 lunch & supper. R20's Physician's orders, dated 2/23, document that R20 has an order dated 1/20/23 to receive Jevity 1.5 375 ml bolus four times a day via gastrostomy tube. However, there is no documentation of R20 having an order to receive the high calorie supplement 90 ml twice a day. R20's MAR, dated 2/23 obtained on 2/6/22 at 3:00 p.m., documents that R20 has an order to receive Jevity 1. 5 375 ml bolus four times a day. The MAR also documents that as of 2/6/23, there is no documentation that R20 received her bolus on 2/4 at 6:00 p.m. & 12:00 a.m. and 2/5 at 6:00 a.m. and 12:00 a.m. nor that she received the high calorie supplement 90 ml twice a day from 2/1-2/6/23. R20's Food & Fluid Intake Sheet, as of 2/6/23 dated 2/23, documents that R20 refused the following meals: 2/1 breakfast & lunch, 2/2 breakfast, 2/3 all three meals, 2/4 breakfast, 2/5 all three meals, and 2/6 breakfast and lunch. The sheet also has no documentation for R20's intakes on the following days: 2/1 supper, 2/2 lunch & supper, 2/4 lunch & supper. R20's care plan, dated 8/19/22, has no documentation of a revision to include R20's significant weight loss. (continued on next page)

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	02/23/2023

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/04/23 at 11:10 am, V32 (Registered Nurse/RN) stated, (V27/Licensed Practical Nurse/LPN) was not feeding (R20) who was to get a tube feed. Several weeks ago, I came on shift and (V27) was giving me report. She was saying how (R20's) tube feeding had been infusing all night. I started to question her, because (R20) didn't have an infusion pump or continuous feeding. (V27) argued that (R20) did have an infusion pump and I just let it go. As soon as (V27) left, I went to (R20's) room. The door was closed. I was right, they didn't' start (R20) on continuous pump, she was still on bolus feedings. (R20) can't talk much, but can say 'yes' or 'no.' She was really agitated when I went in her room, needed oral care, it was obvious it hadn't been done. I asked (R20) if she got fed by the nurse before me and she indicated 'No.' So I gave her her feeding. When I went to the MAR, it was signed off by (V27) as being given. Honestly, I don't think (V27) went into her room all night. We don't even have a tube feeding pump in the building. (R20's) behaviors will increase because she is hungry; I've seen it other times. I will come in and she will be agitated, and her feedings will not be documented as given. As soon as I feed her, her agitation stops. On 2/7/23 at 12:00 p.m., V11 (RN) stated, There was an issue with the facility getting a tube feeding pump when we first got the order. So, it wasn't started right away. I actually spoke with (V40) myself to try and do something different than boluses every three hours because when it's busy it's not easy to get them done every three hours. If you missed one dose by getting side tracked or busy by the time you were able to do it, she was due for her next one. So, she might miss a dose. On 2/7/23 at 12:40 p.m., V40 (Registered Dietician) stated, (R20) should not be losing weight with the amount of calories and protein that she gets on a daily basis from her tube feedings. It gets frustrating. I make recommendations and they don't get followed up with. I added the high calorie supplement twice a day hoping that would help. I was not notified when they changed the tube feeding from continuous overnight back to the boluses. I didn't know about it until I came in for my monthly visits. They should have consulted with me about what to put her on. On 2/7/23 at 1:20 p.m., V24 (Registered Nurse) stated, I don't know that (R20) always gets her feedings or if she does if they are late. I don't want to assume, but her behaviors are escalated when I suspect it. It seems like she has an increase in behaviors. She complains of pain at times too. She will normally tell me she has a headache which could be part of hunger pains. She doesn't eat, and then nurses may not be giving her all of her boluses. This breaks my heart. She can't verbalize. She can't tell us that she is hungry. On 2/7/23 at 4:10 p.m., V41 (Medical Director) stated, (R20) should not have gone without receiving her tube feedings. I agree that these issues needed to be addressed. The DON (Director of Nursing) should be overseeing these things and making sure they are followed through with. However, I know they haven't had a DON for a while. I should have been notified when the facility wasn't able to get the tube feeding supplies and (R20) went without feedings before 11/9/22. (continued on next page)

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	146097	A. Building B. Wing	02/23/2023

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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 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/8/22 at 10:15 a.m., V11 (RN) stated, I know I don't give her high calorie supplement 90 ml with any of my medication passes. V11 confirmed there is no order on the 2/23 MAR for (R20) to receive high calorie supplements at all. V11 stated, (R20) doesn't have many behaviors. When she first got here, she was exit seeking mainly. Now though she will sit on the floor; she learned that from an old roommate. Now the only thing I really notice is the yelling out occasionally. Sometimes, if you ask her, she will say she's having pain; she will shake her head 'yes.' Sometimes, I feel like her yelling out is related to her feedings. I will ask her if she's hungry and she will say 'yes' at times. The yelling out is sometimes when she's due for a feeding as well. There's times too that it's hard to understand what she wants because she will shake her head 'yes' and 'no' to respond to our questions, but sometimes 'yes' looks like 'no' and 'no' looks like 'yes,' and I can't decipher what is wrong. On 2/8/22 at 5:20 p.m., V1 (Administrator in training) stated, (R20's) high calorie supplement was discontinued (1/20/23) in error by one of the nurses. There was no physician order to discontinue the high calorie supplement. On 2/1/23 at 2:25 p.m., V28 (Dietary Manager) stated, Significant weight loss is 5 lbs or more in one month. I don't know the significant weight loss percentages. The CNAs are responsible for charting the residents' intakes at meals. I use the meal intakes for my quarter assessments. I've noticed lots of holes where meals are not charted. I let the nursing department know about it. On 2/16/23 at 11:35 a.m., V48 (Director of Nursing) stated, The doctor and the dietician should have been notified prior to 11/9 that there was no equipment to administer (R20's) continuous feeding. They should have known that we had to keep the boluses going, and then contacted letting them know when the continuous feeding was actually started. The boluses should have continued until the continuous feeding

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	146097	A. Building B. Wing	02/23/2023

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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 0693 Level of Harm - Actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33960 Based on observation, interview, and record review, the facility failed to administer a gastrostomy tube feeding as ordered for one of one resident (R20) reviewed for gastrostomy tube feedings in the sample of 25. As a result of this failure R20 had a significant weight loss of 20 lbs (11.4% weight loss) since R20 was admitted on [DATE] (five months). Findings include: The facility's Enteral Tube Feeding Bolus Procedure policy, undated, documents, It is the policy of the Facility to provide nutrition via Nasogastric or Gastrostomy tubes when ordered by physician. The resident may receive nutrition and hydration either by intermittent, continuous, or bolus feeding into the stomach by means of a tube when the oral route cannot be used. The policy also documents, Report unusual observations/findings to the physician. Report observations regarding feeding tolerance to the dietician. Document information related to feeding on flow record and/or TAR (Treatment Administration Record)/MAR (Medication Administration Record). On 2/6/23 at 2:00 p.m., R20 was lying in her bed on her right side with her eyes open. When spoken to, she lifted her head, made eye contact and laid back down without responding. On 2/6/23 at 3:30 p.m., R20 was partially sitting up in bed with a flat affect and no verbalization. Questions asked to R20. R20 did not respond verbally. However, did respond at times with a thumbs up or thumbs down partially, but it was hard to understand her response. R20 became frustrated and laid back down facing the wall. R20's Report of Monthly Weights and Vitals, dated 2022, documents: R20's Admission weight on 8/6/22 was 176 lbs (pounds); 9/22 weight was 170 lbs (6 lbs 3.4% weight loss in one month); 10/22 weight was 160 lbs (10 lbs 5.9% weight loss in one month); 11/22 weight was 161 lbs (15 lbs 8.5% weight loss in three months); 12/22 weight was 157 lbs (13 lbs 7.6% weight loss in three months). R20's TAR (Treatment Administration Record), dated 1/23, documents R20's most recent weight was 156 lbs (20 lbs 11.4% weight loss in five months) on 1/19/23. R20's Physician's orders, dated 8/22, documents that R20 was admitted on [DATE] with an order to receive Jevity 1.2 237 ml (milliliters) via gastrostomy tube every three hours. R20's MAR (Medication Administration Record), dated 8/6-8/30/22, documents that R20 is to receive Jevity 1. 2 237 ml via gastrostomy tube every three hours, and there is no documentation that R20 received the Jevity bolus on the following dates/times: 8/7 - 6:00 p.m., 3:00 a.m.; 8/8 - 6:00 p.m., 3:00 a.m.; 8/9 - 3:00 a.m.; 8/10 - 6:00 p.m., 9:00 p.m., 3:00 a.m.; 8/11 - 6:00 a.m., 9:00 p.m., 12:00 a.m., 3:00 a.m.; 8/12 - 3:00 p.m., 6:00 p. m., 12:00 a.m., 3:00 a.m.; 8/13 - 3:00 a.m.; 8/14 - 6:00 a.m., 12:00 p.m., 12:00 a.m., 3:00 a.m.; 8/15 - 6:00 a. m.; 8/16 - 12:00 a.m., 3:00 a.m.; 8/18 - 9:00 p.m.; 8/19 - 6:00 a.m., 12:00 a.m., 3:00 a.m.; 8/20 - 6:00 p.m.; 8/22 - 9:00 p.m.; 8/25 - 9:00 a.m., 3:00 p.m., 6:00 p.m. 9:00 p.m.; 8/30 - 6:00 p.m.; 8/31 - 9:00 p.m. for a total of 36. (continued on next page)

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	146097	A. Building B. Wing	02/23/2023

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F 0693 Level of Harm - Actual harm Residents Affected - Few	R20's Dietary Services Communication, dated 9/21/22 and signed by V40 (Registered Dietitian), documents, Observations: Nurse requests continuous feed for tube feeding. Gradual weight loss. Recommendations: Recommend Jevity 1.2 at 150 ml/hr for 12 hours overnight with 200 ml FWF three times a day during feedings. The communication also documents that the physician acknowledged and approved the recommendation on 10/20/22. R20's MAR, dated 9/22, documents that R20 is to receive Jevity 1.2 237 ml via gastrostomy tube every three hours, and there is no documentation that R20 received the Jevity bolus on the following dates/times: 9/1 - 6:00 p.m.; 9/6 - 6:00 p.m., 9:00 p.m.; 9/7 - 6:00 a.m., 9:00 a.m., 12:00 p.m., 3:00 p.m., 6:00 p.m., 12:00 a.m., 3:00 a.m.; 9/8 - 9:00 p.m.; 9/10 - 9:00 p.m.; 9/11 - 12:00 a.m., 3:00 a.m.; 9/12 - 6:00 a.m., 12:00 a.m., 3:00 a.m.; 9/14 - 9:00 p.m.; 9/19 - 6:00 p.m.; 9/20 - 6:00 p.m., 9:00 p.m.; 9/21 - 6:00 a.m., 9:00 a.m., 12:00 p.m., 3:00 p.m., 12:00 a.m., 3:00 a.m.; 9/22 - 6:00 p.m.; 9/23 - 6:00 p.m.; 9/24 - 6:00 p.m.; 9/25 - 6:00 p.m., 9:00 p.m.; 9/26 - 12:00 a.m., 3:00 a.m.; 9/27 - 6:00 p.m.; 9/28 - 6:00 p.m.; 9/29 - 6:00 a.m., 12:00 a.m., 3:00 a.m.; 9/30 - 6:00 a.m. for a total of 40. R20's Dietary Services Communication, dated 10/18/22 and signed by V40, documents, Observation: Gradual weight loss for 30 days. R20's Physician's orders, dated 10/22, document that R20 received an order on 10/20/22 for Jevity 1.2 at 150 ml/hr for 12 hours overnight with a 200 ml flush three times during feedings and a 30 ml flush twice a day before and after medications. R20's MAR, dated 10/22, has no documentation of R20 receiving her Jevity 1.2 237 ml every three hour bolus on the following dates/times: 10/1 - 3:00 p.m., 3:00 a.m.; 10/6 - 9:00 p.m.; 10/7 - 6:00 p.m.; 10/9 - 9:00 p.m.; 10/12 - 9:00 p.m.; 10/13 - 9:00 p.m., 12:00 a.m.; 10/16 - 9:00 p.m.; 10/17 - 6:00 p.m., 12:00 a.m., 3:00 a.m.; 10/27 - 12:00 a.m., 3:00 a.m.; 10/28 - 9:00 p.m., 10/29 - 9:00 p.m.; 10/30 - 12:00 p.m., 9:00 p.m.; 10/31 - 9:00 p.m. for a total 19. R20's MAR also documents that R20's order to receive Jevity 1.2 at 150 ml/hr overnight with 200 ml FWF three times a day during feedings was not started until 10/27/22 and there is no documentation of R20 receiving the overnight feeding on 10/29 or 10/30. R20's MAR (Medication Administration Record), dated 11/22, documents that R20 was to receive Jevity 1.2 for twelve hours overnight at a rate of 150 ml/hr being turned on at 8:00 p.m. and turned off at 8:00 a.m. The MAR has no documentation of R20 being administered the feeding on 11/3, 11/5, 11/6, and 11/9 as well as 11/1, 11/2, 11/7, 11/8 were circled as R20's tube feeding was not administered. In the same section that this tube feeding is signed off is a handwritten statement, On hold; pending discontinue-R20 doesn't remain still. The MAR documents that R20 was restarted on Jevity 1.5 237 ml bolus every three hours on 11/9 at 12:00 p.m. There is no documentation of R20 receiving the bolus on the following dates/times: 11/9 - 12:00 a.m. & 3:00 a.m.; 11/10 - 12:00 p.m., 3:00 p.m., 6:00 p.m., 9:00 p.m.; 11/12 - 9:00 p.m.; 11/13 - 3:00 p.m., 6:00 p.m., 9:00 p.m.; 11/14 - 12:00 a.m., 3:00 a.m.; 11/15 - 9:00 p.m., 11/16 - 6:00 a.m., 12:00 a.m., 3:00 a.m., 11/17 - 6:00 p.m.; 11/18 - 6:00 a.m., 6:00 p.m.; 11/19 - 6:00 p.m., 9:00 p.m., 12:00 a.m., 3:00 a.m.; 11/20 - 6:00 p.m.; 11/21 - 6:00 p.m.; 11/22 - 6:00 a.m.; 11/24 - 6:00 a.m., 12:00 p.m., 3:00 p.m., 6:00 p.m., 9:00 p.m.; 11/25 - 6:00 a.m., 9:00 a.m., 12:00 p.m., 3:00 p.m., 6:00 p.m.; 11/26 - 3:00 p.m.; 11/27 - 6:00 a.m., 6:00 p.m.; 11/29 - 3:00 p.m., 6:00 p.m. for a total of 41. (continued on next page)

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	02/23/2023

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F 0693 Level of Harm - Actual harm Residents Affected - Few	On 12/7/22 at 12:00 p.m., V11 (Registered Nurse) stated, There was an issue with the facility getting a tube feeding pump when we first got the order. So, it wasn't started right away. I actually spoke with (V40) myself to try and do something different than boluses every three hours because when it's busy it's not easy to get them done every three hours. If you missed one dose by getting sidetracked or busy by the time you were able to do it, she was due for her next one. So, she might miss a dose. R20's Nurses' notes, dated 11/9/22 at 9:00 p.m., document, Fax sent to doctor to discontinue pump feeds and continue with bolus feeds every three hours due to safety concerns related to inability to remain in bed for 12 hours. R20's Physician notification form, dated 11/9/22, documents, R20 has gastrostomy tube and was ordered for 12 hour of Jevity 1.2 at 50 ml/hr. R20 does not remain still and is constantly getting up and walking halls. Unsafe to be hooked to machine for any length of time. Please consider returning to bolus feeds of Jevity 1.5 237 ml every three hours. The form also documents the physician's order to refer to dietician for orders. On 2/7/23 at 1:20 p.m., V24 (Registered Nurse) stated, I don't work that hall too often. The facility was having difficulty getting the right equipment for (R20's) continuous feeding. We didn't have the equipment until the night of the 9th. I was the first one to hook her up for the feeding when we had the right equipment. I attempted to do the feeding and she wouldn't stay in the bed, and she was wanting to leave the room. The tubing was stretching, and it just wasn't working. So I contacted the doctor about getting them stopped and switched back to the bolus feedings. I did the bolus feedings as she previously had ordered. I mentioned it to the other nurses that nobody was signing out a bolus feed, but they were circling that the continuous feed wasn't getting done. It looks like we aren't feeding her. I don't know that all of the nurses were giving her the normal schedule of bolus feeding during that time. I know it wasn't on the MAR to give them. I was terrified to put my name in the book, so I contacted the doctor. If it's not signed off in the MAR, then you can only assume it's not done. I don't know of anyone notifying the physician prior to that evening. R20's Dietary Notes, dated 11/16/22 and signed by V40, document, CBW 161 lbs. Significant weight loss noted: 8.5% in 90 days. R20's Dietary notes, dated 12/13/22 and signed by V40, documents, CBW 157 lbs. Significant weight loss noted: 7.65% in 90 days. Weight trending down in 30 days. R20's MAR, dated 12/22, has no documentation of R20 receiving her Jevity 1.5 237 ml every three hour bolus on the following dates/times: 12/3 - 6:00 a.m., 6:00 p.m.; 12/4 - 3:00 p.m., 6:00 p.m.; 12/7 - 9:00 p.m.; 12/13 - 12:00 a.m., 3:00 a.m.; 12/17 - 6:00 a.m., 6:00 p.m., 9:00 p.m.; 12/19 - 6:00 p.m.; 12/21 - 6:00 p.m., 9:00 p.m.; 12/22 - 9:00 p.m.; 12/26 - 3:00 p.m. for a total of 15. R20's MAR, dated 1/23, documents from 1/7-1/20 R20 had an order to receive Jevity 1.2 474 ml bolus four times a day, and there is no documentation of R20 receiving the bolus on 1/11 at 6:00 a.m. and 12:00 a.m. The MAR also documents that this order was discontinued on 1/20/23 and Jevity 1.5 375 ml bolus four times a day was started. There is no documentation of R20 receiving that bolus on 1/21 at 6:00 p.m. or 1/30 at 12:00 p.m. (continued on next page)

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	02/23/2023

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F 0693 Level of Harm - Actual harm Residents Affected - Few	R20's Physician's orders, dated 2/23, document that R20 has an order dated 1/20/23 to receive Jevity 1.5 375 ml bolus four times a day via gastrostomy tube. R20's MAR, dated 2/23 obtained on 2/6/22 at 3:00 p.m., documents that R20 has an order to receive Jevity 1. 5 375 ml bolus four times a day. The MAR also documents that as of 2/6/23, there is no documentation that R20 received her bolus on 2/4 at 6:00 p.m. & 12:00 a.m. and 2/5 at 6:00 a.m. and 12:00 a.m. On 2/04/23 at 11:10 am, V32 (Registered Nurse) stated, (V27/Licensed Practical Nurse/LPN) was not feeding (R20), who was to get a tube feed. Several weeks ago, I came on shift and (V27) was giving me report. She was saying how (R20's) tube feeding had been infusing all night. I started to question her, because (R20) didn't have an infusion pump or continuous feeding. (V27) argued that (R20) did have an infusion pump and I just let it go. As soon as (V27) left, I went to (R20's) room. The door was closed. I was right, they didn't' start (R20) on continuous pump, she was still on bolus feedings. (R20) can't talk much, but can say 'yes' or 'no.' She was really agitated when I went in her room, needed oral care, it was obvious it hadn't been done. I asked (R20) if she got fed by the nurse before me and she indicated 'No.' So I gave her her feeding. When I went to the MAR, it was signed off by (V27) as being given. Honestly, I don't think (V27) went into her room all night. We don't even have a tube feeding pump in the building. (R20's) behaviors will increase because she is hungry. I've seen it other times. I will come in and she will be agitated, and her feedings will not be documented as given. As soon as I feed her, her agitation stops. On 2/7/23 at 12:40 p.m., V40 (Registered Dietician) stated, (R20) should not be losing weight with the amount of calories and protein that she gets on a daily basis from her tube feedings. It gets frustrating. I make recommendations and they don't get followed up with. I was not notified when they changed the tube feeding from continuous overnight back to the boluses. I didn't know about it until I came in for my monthly visits. They should have consulted with me about what to put her on. On 2/7/23 at 1:20 p.m., V24 (Registered Nurse) stated, I don't know that (R20) always gets her feedings or if she does if they are late. I don't want to assume, but her behaviors are escalated when I suspect it. It seems like she has an increase in behaviors. She complains of pain at times too. She will normally tell me she has a headache, which could be part of hunger pains. She doesn't eat, and then nurses may not be giving her all of her boluses. This breaks my heart. She can't verbalize. She can't tell us that she is hungry. On 2/7/23 at 4:10 p.m., V41 (Medical Director) stated, (R20) should not have gone without receiving her tube feedings. I agree that these issues needed to be addressed. On 2/8/22 at 10:15 a.m., V11 stated, (R20) doesn't have many behaviors. When she first got here she was exit seeking mainly. Now though she will sit on the floor; she learned that from an old roommate. Now the only thing I really notice is the yelling out occasionally. Sometimes, if you ask her, she will say she's having pain; she will shake her head 'yes.' Sometimes, I feel like her yelling out is related to her feedings. I will ask her if she's hungry and she will say 'yes' at times. The yelling out is sometimes when she's due for a feeding as well. There are times too that it's hard to understand what she wants because she will shake her head 'yes' and 'no' to respond to our questions, but sometimes 'yes' looks like 'no' and 'no' looks like 'yes,' and I can't decipher what is wrong. (continued on next page)

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	146097	A. Building B. Wing	02/23/2023

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F 0693 Level of Harm - Actual harm Residents Affected - Few	On 2/8/23 at 1:50 p.m., V3 (Resident Care Coordinator/Acting Director of Nursing/DON) stated, Nurses should be documenting when they administer medications or treatments on their MARs and TARs. If they don't sign it off, we don't know if it was done. The rule of thumb is if no signature, then it wasn't done. On 2/16/23 at 11:35 a.m., V48 (Director of Nursing) stated, The doctor and the dietician should have been notified prior to the 11/9 that there was no equipment to administer (R20's) continuous feeding. They should have known that we had to keep the boluses going, and then contact them letting them know when the continuous feeding was actually started. The boluses should have continued until the continuous feeding was started. I don't see where (R20) got any type of feeding from 11/1-11/9. V48 also confirmed the lack of documentation that R20 received her scheduled g-tube feedings.

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	146097	A. Building B. Wing	02/23/2023

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 23028 Based on interview and record review, the facility failed to employ a Director of Nursing (DON) to oversee the operation of the Nursing Department and ensure quality of care. This had the potential to affect all 116 residents residing in the facility. Findings include: The Facility's Director of Nursing job description (no date) documents, Job Summary: To plan, organize, develop and direct the overall operation of our Nursing Service Department in accordance with current federal, state and local standards, guidelines, and regulations that govern our facility and as may be directed by the Administrator and the Medical Director to ensure that he highest degree of quality care is maintained at all times. The Director of Nursing job description outlines, under Nursing Care Nursing Care, 1. Participate in the screening of residents for admission to the facility. 2. Provide the Administrator with information relative to the nursing needs of the resident and the nursing service department's ability to meet those needs. 3. Inform nursing service personnel of new admissions, their expected time of arrival, room assignment, etc. 4. Ensure that rooms are ready for admissions. 5. Make rounds with physicians as necessary. Schedule physician visits as necessary. 6. Encourage attending physicians to record and sign progress notes, physicians' orders, etc., on a timely basis and in accordance with current regulations. 7. Ensure that direct nursing care be provided by a licensed nurse, a CNA qualified to perform the procedure. 8. Review nurses' notes to ensure that they are informative and descriptive of the nursing care being provided, that they reflect the resident's response to the care, and that such care is provided in accordance with the resident's wishes. 9. Schedule daily rounds to observe residents and to determine if nursing needs are being met in accordance with the resident's needs. 10. Monitor medication passes and treatment schedules to ensure that medications are being administered as ordered and that treatments are provided as scheduled. 11. Provide direct nursing care as necessary. 12. Authorize the use of restraints when necessary and in accordance with our established policies and procedures. 13. Implement and monitor programs (falls, skins, weights, etc.,) in accordance with our established policies and procedures. The Staff Phone List, dated 1/25/23, documents the DON position is vacant. Upon entering the facility on 1/24/23 at 9:15 am, V1 (Administrator in Training) introduced V2 as her Assistant Administrator in Training and V3 (Licensed Practical Nurse/Resident Care Coordinator) as her Acting DON (Director of Nursing). On 1/25/23 at 11:25 am, V1 stated the facility has not had someone in the position of DON for some time, but V3 has been filling in until the new DON can start. (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/01/23 at 9:58 am, V3 (Licensed Practical Nurse/Resident Care Coordinator) clarified that she was only hired in as an RCC (Resident Care Coordinator) and that she does the scheduling of nursing staff, but has not been doing any actual DON duties, such as over site of Physician's Orders or resident care delivered by the licensed nursing staff and CNAs (Certified Nursing Assistants). V3 was questioned about her lack of involvement in the operations of the Nursing Services Department, as she had been identified and introduced at the start of the survey as the Acting DON. V3 reiterated that was not her role. On 2/7/23 at 4:10 pm V41 (Medical Director) agreed during interview that the facility has had issues processing physician's orders correctly. V41 stated, The DON should be overseeing these things and making sure they are followed through with. However, I know they haven't had a DON for a while. On 2/04/23 at 11:10 am, V32 (Registered Nurse) stated the facility doesn't have a DON, and The lack of leadership is obvious. V32 stated basic nursing tasks are not being done, such as processing physician's orders (for medication, testing, labs), oral care and medication administration. V32 stated V27 (Licensed Practical Nurse) will sign off that medications have been given, when they have not, and she has caught CNAs sleeping at night. V32 stated this is reported to Management, but nothing is done about it. V32 stated V3 will prep the residents' medication, by popping them out into a cup and putting them in the drawer of the medication cart for other nurses to pass. V32 stated, I told the Agency I couldn't work there anymore; residents are not taken care of. The facility's CMS (Centers for Medicare and Medicaid Services) Resident Census and Conditions of Residents Form 672, dated 1/24/23 and signed by V1, documents that 116 residents reside in the facility.

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. 23028 Based on interview and record review, the facility failed to ensure all staff had the appropriate knowledge and training to care for residents with a mental disorder, for one of 24 residents reviewed (R3) with a mental illness diagnosis, in a sample of 24. This failure has the potential to affect all 116 residents currently living in the facility. Findings include: The Facility Assessment (updated 4/20/21) documents the facility provides services to patients having a variety of mental health illnesses as well as medical needs and identifies under Resident Support/Care Needs: 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. The Facility Assessment also documents, Staff training is required for all departments upon hire and annually. At the time of orientation, the SWAT program covers many of the required and necessary education needed to begin employment. General training topics (this is not an inclusive list): Communication - effective communications for all direct care staff; Resident's rights and facility responsibilities of a facility to properly care for its residents. The Facility Assessment documents the following individuals as being involved with its completion: V1 (Administrator in Training), V2 (Assistant Administrator in Training), V3 (Resident Care Coordinator/Licensed Practical Nurse), V31 (Vice President of Business Development and Strategy/Regional Director of Operations), V48 (Director of Nursing) and V41 (Medical Director). Resident Council Meeting Minutes, dated 1/10/23, document under Administration, resident concerns that staff are not trained in Behavioral Health Management. A Physician's Order sheet, dated 1/01/23, documents R3 has the diagnoses of Major Depression, Post Traumatic Stress Disorder and Somatic Disorder. R3's current Plan of Care (no date) document R3 is known/has history of displaying inappropriate behavior and/or resisting care/services and likes to call (Public Health) and encourages other residents to call (Public Health) and threaten nurses and staff he will call (Public Health) and lawyers. R3's Plan of Care instruct staff to Introduce self upon contact, make eye contact, approach from front, explain all procedures prior to beginning, seek resident input/reassurance with all cares; During periods of inappropriate behavior, use a consistent, calm, firm approach. Use resident's name to help divert inappropriate behavior; Provide reality orientation as tolerated; During episodes of inappropriate behavior, attempt to determine source of agitation by asking open ended questions and seek to resolve; Allow resident time and opportunity to express self and verbalize frustrations; Help resident to understand why behavior is inappropriate/disruptive and the impact it has on personal well-being of others. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/20/23, V10 (Ombudsman) documented via email that she received a call from R3, who was concerned because V3 (Resident Care Coordinator/Licensed Practical Nurse) had called the Police Department on him that day, alleging that he threatened her when he had not. According to V10's email, R3 was upset over a delay in his medication and V3 informed R3 she would not look into the issue and became verbally aggressive with R3 during the conversation. On 2/23/23 at 8:50 am, R3 stated he recently stopped taking his prescribed narcotic for pain, because he does not want to be on them any longer. R3 stated the Physician had ordered Topamax for him to try for his headaches, in place of the narcotic, approximately 7 days ago. R3 stated on 2/20/23, he approached V3 at the nurses' station and asked if she knew the status of his new medication. R3 stated V3 told him that she had submitted the order and that was all she was going to do at that point, as I've done my job. R3 asked V3 if she could do more to get his medicine, because I was in pain. R3 stated V3 started talking over him, put her hand up and said Bye! Go deal with (V1). R3 stated he did talk to V1, who was very helpful. R3 stated when he left V1's office and was walking past the nurses' station to go to his room, as he did, he told V3, (V1) is doing your job for you. R3 stated V3 started yelling and talking over me and said Get back, get the f**k back! R3 stated the wall of the nurses' station was between them, he never came towards V3. R3 did admit to saying you are being a b***h to V3. According to R3, V3 then yelled at him, I'm calling the police! and told the 911 Dispatch Operator that R3 was reaching across the nurses' station, threatening, and harassing her. R3 stated other staff were around, but no one intervened or did anything. R3 stated the police did come to the facility and talked to him, but nothing happened. R3 stated he feels like V3 is angry and retaliating over a prior dispute they had about medication in January. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/23/23 at 9:12 am, V3 was contacted via phone and asked if she could go into detail regarding why she called 911 on R3 (2/20/23). V3 advised she had written a progress note detailing what had occurred, and she was not able to be interviewed further at that time. A call back was requested, but not received. During a previous interview with V3, on 2/01/23 at 9:58 am, V3 stated she was hired by the facility as a Resident Care Coordinator (October 2022). During that interview, V3 stated she had not received any training on Behavioral Health or behavior management of mentally ill residents. V3's Nursing Note, dated 2/20/23, documents the following, (R3) came to the nurses' station with (V2). I was questioned about a medication that the resident was due to receive (at) 8:00 am. (At 8:00 am) the resident never asked me anything but waited (until) now to question it. I explained to both (V2 and R3) that in report I was told the proper steps were (taken) and that the facility signed for the (medication) and that it should be in this evening. (R3) continued to ask why it was not in and that it had been days. I again apologized on the staff behalf. (R3) got upset and started yelling that if it was insulin, this wouldn't happen and that the medication was important. I stated you are right, the Pharmacy provides back up for insulin and not that (medication). (R3) started talking with his hands and yelling. I stated I'm sorry I've done what I could, if you have any more concerns, please address (V1). (R3) continued to yell at me and call me stupid. I said could you please step away from the nurses' station. (R3) stated You can do your job b***h;' I stated this behavior will not be tolerated; can you please step away from the nurses' station. (R3) stated Shut the f**k up b***h.' I stated if you don't stop harassing me, I will have to call the police for harassment. (R3) walked away and stated 'I will be back b***h.' (R3) walked towards the front and came right back to the nurses' station where I was sitting and stated '(V1) is going to do your job b***h.' I again stated please top harassing me and he stated 'I don't care, call the police. I am going to call State. This is retaliation, you already have a case, you will be suspended and eventually fired.' I called 911 and he continued to talk and yell, telling the other residents what (happened). I did not say anything else at that time. Another resident came up and was looking for her nurse. I heard her say she was telling (V1). I said to the resident your nurse is right here. This resident stated there is another reason to call State on your a**. I said I'm sorry, I'm not her nurse. (R3) stated 'So what, (you're) head of nursing.' I feel attacked by this resident anytime I am a floor nurse. (R3) finds reason to argue with me. The (Topamax) was due to be given (at 8:00 am), (R3) never asked me questions, but went to (V2) to tell (her) that I didn't give it (at 12:45 pm). On 2/23/23 at 9:55 am, V1 stated R3 came to her on 2/20/23, asking about the process for getting his Topamax. V1 explained to R3 that there is an apparent insurance coverage issue, and he left her office. V1 stated after that, I did hear (R3) say 'f*****g b***h.' By the time I came out of my office to see what was going on, (V3) had already called the police because '(R3) flipped out on her.' V1 concluded that nothing was done by V3 or other staff to minimize the incident or avoid the police being called on R3. V2 was present during that interview and stated she was present at nurses' station for some of the incident but did not witness the entire thing. V2 described R3 as standing outside of the nurses' station and V3 was sitting behind the half wall. V2 stated she did hear R3 call V3 a b***h but was not at the nurses' station when V3 called the police on R3, so she cannot account for everything that occurred. V2 denied anyone trying to deescalate the issue or redirect R3 or V3 away from the situation. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/21/23 at 9:27 am, V26 (Registered Nurse) stated she was present on 2/20/23 at the nurses' station for the entire incident between V3 and R3. According to V26, R3 approached V3 and asked if his new medication had arrived. V26 stated R3 is currently trying to wean himself off a narcotic, which is why he was so concerned about the medicine. V26 stated R3 was initially calm, but V3 was immediately confrontational with R3. V26 confirmed that R3 did call V3 a b***h, but that was after V3 had provoked him. V26 stated she police should have never been called, because R3 never threatened V3. V26 stated the staff in the facility have no training in mental health, so they don't know how to handle behaviors of mentally ill residents. V26 stated, They (Staff) don't know how to redirect (residents), and staff escalate the problems sometimes. V26 stated V3's documented account of the incident in R3's medical record on 2/20/23 is not what occurred. On 2/04/23 at 11:10 am, V32 (Registered Nurse) stated there is no training on anything for new staff, on abuse or how to deal with (mentally ill population); it leads to lots of issues between residents and staff. On 2/7/23 at 1:20 p.m., V24 (Registered Nurse) stated, This facility does not offer any training to their staff when it comes to this population. I know we have to have dementia training, but this is Mental Illness. These residents could hurt someone. The staff do not know how to take care of these types of behaviors, and there's no one to turn to. So, they call 911 or send them to the hospital hoping they might spend a few days there. This doesn't help anything, and at times makes it worse. We have all these young kids working here, too. They don't know how to handle the situation, and they think the answer is to come to the nurse. Sometimes though it's too late, and someone could be hurt. On 2/02/23 at 1:59 pm, V4 (Social Service Director) stated when she started in her position as Social Services Director she had no experience with the mentally ill. V4 stated she received no training or education on how to help residents with mental illness. On 2/23/23 at 11:36 am, V50 (Police Chief) confirmed that on 2/20/23 a 911 call was received from V3, who told the dispatcher that a resident was threatening her. V50 stated they took the call as the resident was threatening to physically hurt the individual. V3 stated, when the responding officer arrived at the facility, he determined that R3 had yelled at the nurse and called her a name, and there was no real threat made to (V3). V50 stated 48% of this Department's calls come from this facility, and it's residents and staff calling. Staff have a hard time deescalating issues and call us for help; typically there is not much we can do to assist in the situation. On 2/23/23 at 9:44 am, V1 described the facility as, This is a Mental Health Facility. V1 stated V3 was hired in October 2022. V1 described V3 as a newer nurse, like a couple of years with no previous psychiatric experience that she is aware of. V1 stated she started as the Administrator in Training on August 22, 2022, and since she has been in that position, no new staff have received any behavioral health training. A Staffing List, dated 1/25/23, documents the following staff members as being new employees who started after V1 was hired on 8/22/22: V2, V3, V11 (Licensed Practical Nurse), V51 (Licensed Practical Nurse), V52 (Registered Nurse), V53 (Registered Nurse), V7 (Registered Nurse), V54, V63, V33, V64, V65, V19 (all Certified Nursing Assistants), V34, V55, V9, V35, V56, V57, V58 (all Unit Aides), V59 (Transportation Aide), V15 (Social Service), V14, (Social Service), V60 (Activities Aide) and V61 (Activities Aide). (continued on next page)

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	146097	A. Building B. Wing	02/23/2023

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The CMS-672 (Resident Census and Conditions of Residents), dated 1/24/23 and signed by V1 (Administrator in Training), documents 116 residents currently live in the facility.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 23028 Based on interview and record review, the facility failed to administer insulin as ordered by the physician, for one of three residents (R4) reviewed for medication administration, in a sample of 25. Findings include: The facility policy, titled Medication Administration (revised 11/18/17), documents Policy: Drugs and biologicals are administered only by physicians and licensed nursing personnel. Definition: Drug administration shall be defined as an act in which a single dose of a prescribed drug or biological is given to a resident by an authorized person in accordance with all laws and regulations governing such acts. The complete act of administration entails removing an individual dose from a previously dispensed, properly labeled container (including a unit dose container), verifying it with the physician's orders, giving the individual dose to the proper resident, and promptly recording the time and dose given. Responsibility: Licensed nursing personnel; Procedure: 1. Routine Times of Medication Administration: 2. Each facility shall establish a policy for the routine time of medication administration. 3. Medications must be prepared and administered within one hour of the designated time or as ordered. (I.e., Medication time is 9:00 AM. The medication can be administered as early as 8:00 AM and as late as 10:00 AM. Medication is ordered as daily then medication can be given during the day at resident's preference). 4. Set up medication cart to ensure all needed items are available (i.e., medication cups, water cups, applesauce, syringes, pill crusher, etc.). 5. Keep the medication cart in view at all times. If it is likely the medication cart will be out of visual control at any time, it must be locked. 6. Medications must be identified by using the seven (7) rights of administration: Right resident; Right drug; Right dose; Right consistency; Right time; Right route; Right documentation. A Physician's Order Sheet, dated 1/01/23, documents R4 has the diagnosis of Type 2 Diabetes Mellitus, and is to receive Insulin Glargine 10 Units sub-q once daily at 8:00 am and Lispro Insulin 100 Units/ml (milliliter) sub-q, based on a sliding scale, four times per day (8:00 am, 11:00 am, 4:00 pm, 8:00 pm). R4's Lispro Insulin Sliding Scale order is as follows: Accucheck of 151-180 administer 1 Unit Accucheck of 181-200 administer 2 Units Accucheck of 201-250 administer 4 Units Accucheck of 251-300 administer 6 Units Accucheck of 301-350 administer 8 Units Accucheck of 351-400 administer 10 Units Accucheck greater than 400 administer 12 Units (continued on next page)

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	146097	A. Building B. Wing	02/23/2023

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R4's Medication Administration Record, dated 1/01/23, documents R4 has received Insulin Glargine 10 Units sub-q at 8:00 am and 8:00 pm on the following dates: 1/01/23, 1/03/23, 1/06/23, 1/08/23, 1/12/23, 1/13/23, 1/14/23, 1/17/23, 1/23/23 and 1/25/23. R4's Medication Administration Record, dated 1/01/23, documents R4 did not receive Insulin Glargine 10 Units sub-q at 8:00 am, but instead at 8:00 pm, on the following dates: 1/02/23, 1/10/23, 1/19/23 and 1/24/23. R4's Medication Administration Record documents the following errors: On 1/04/23 at 11:00 am - No accucheck and no insulin administered; On 1/06/23 at 8:00 pm an accucheck of 216 with no insulin administered; On 1/07/23 at 8:00 am an accucheck reading of 190 and no insulin was given and at 8:00 pm an accucheck of 327 with only 4 units of insulin given; On 1/08/23 at 4:00 pm an accucheck of 237 with no insulin administered; On 1/19/23 at 8:00 am an accucheck of 187 with no insulin administered and at 11:00 am an accucheck of 308 with no insulin administered; On 1/20/23 at 4:00 pm an accucheck of 1 and no insulin administered. On 2/02/23 at 10:04 am, V3 (Resident Care Coordinator/Licensed Practical Nurse) stated any areas on R4's Medication Administration Record that has no initials or is blank, would indicate that the medication was not given. V3 stated there should be a corresponding nursing note as to why the medication wasn't given, as well. V3 could not explain why R4 was receiving the scheduled Insulin Glargine 10 Units twice per day on some days in January and agreed the Physician's Order was for 10 units at 8 am only. On 1/24/23 at 2:00 pm, R4 stated she has frequent issues with staff either not giving her insulin or giving her the wrong dose. R22 (R4's roommate) stated there was a recent day when V27 (Licensed Practical Nurse) double dosed R4's insulin, giving her two doses within 90 minutes. R22 stated R4 became lethargic and wasn't responding to her, so she fed her yogurt. According to R22, V27 came in and was unable to even get a blood sugar reading on R4, because her blood sugar was so low. R4 then stated she barely remembers what happened that day because her blood sugar was so low, but she does remember telling V27 that she was giving her the insulin too early, but she didn't listen.

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	146097	A. Building B. Wing	02/23/2023

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F 0770 Level of Harm - Actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. 33960 Based on interview and record review, the facility failed to obtain laboratory draws as ordered by a physician for one of three residents (R1) reviewed for laboratory values in the sample of 25. This failure resulted in R1 being hospitalized with a critically low Valproic acid level. Findings include: The facility's Laboratory Tests policy, no date available, documents, Laboratory testing will be completed in collaboration with Medicare guidelines, pharmacy recommendations, and physician orders. Obtain laboratory orders upon admission, readmission, and PRN (as needed) for medication and condition monitoring per the physician's orders. R1's Physician's orders, dated 10/22, document the following orders: 10/18/22 Increase Depakote to 1125 mg by mouth three times a day. Check Depakote (Valproic Acid) level in one week. R1's most recent Valproic blood level, dated 9/30/22, documents a level of 46 low (Normal 50-100). The facility was unable to provide any Valproic acid levels after this date. R1's Hospitalist Admission History and Physical, dated 1/17/23, documents, R1 with severe schizophrenia, tardive dyskinesia, seizure disorder brought in from facility with complaints of lethargy and worsening tremors. R1 is lethargic, barely responsive, and thus unable to contribute to the history. History was obtained from emergency department records and from her mother at the bedside. The History & Physical also documents, Depakote level is subtherapeutic. R1's Hospital Progress note, dated 1/19/23, documents that R1's Valproic Acid is less than 13 (Normal 50-125). On 2/2/23 at 9:30 a.m., V1 (Administrator in Training) confirmed that R1's most recent Valproic acid level was drawn on 9/30/22. On 2/8/23 at 1:50 p.m., V3 (Resident Care Coordinator/Acting Director of Nursing) stated, The laboratory comes to our facility every Monday, Wednesday, and Friday unless it is a stat (as soon as possible) order. If it is stat, they come right away. If the physician orders for a lab to be drawn I would expect it to be done on the next scheduled lab draw day.

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. 33960 Based on observation, interview, and record review, the facility failed to obtain physician ordered radiology services for two of three residents (R1, R5) reviewed for physician ordered radiology services in the sample of 25. Findings include: 1. R1's Nurses' notes, dated 9/13/22 at 5:50 p.m., document, Assistant Director of Nursing notifies this nurse R1 having choking episode to call ambulance. Ambulance contacted. Assistant Director of Nursing performing Heimlich as R1 is not responding and oxygen saturations decreased. Able to loosen obstruction. R1 responsive and breathing when ambulance arrives. Transported to hospital for evaluation. R1's Emergency Department Discharge Instructions, dated 9/13/22, document, Have speech pathology work with R1 and continue mechanical soft diet. Chief Complaint: R1 with report of choking on her food. Facility nurse able to clear obstruction prior to ambulance arrival. R1 with history of choking on food. Ambulance states R1 has chocked twice in the last month. R1's Physician's orders, dated 9/22, document the following order: 9/22/22 referral for cookie swallow - diagnosis choking. R1's Hospital Speech Therapy notes, dated 11/22/22, History and Physical: R1 was referred to speech therapy by physician for recurring episodes. Recommendations: If total feed assist can be provided then regular consistency with thin liquids is recommended. If total assist cannot be provided, recommend minced and moist with thin liquids. The notes also document that these recommendations are a result of R1's barium swallow results. On 2/1/23 at 1:49 p.m., V6 (Certified Nursing Assistant/Scheduler) stated, (R1) had her cookie swallow done on 11/22/22. V6 also confirmed that this cookie swallow was from the physician order on 9/22/22. 2. On 1/24/23 at 11:50 a.m., R5 was alert but nonverbal sitting up on the side of her bed. R5 sits up and then lies down with almost constant spastic movements. R5's CT (Computed Tomography) of head or brain without contrast results, dated 7/28/22, documents, Impression: Correlation with patient history and further evaluation with MRI is recommended. The results also document that the physician circled this statement and wrote get and signed his name. On 1/24/23 at 1:30 p.m., V11 (Registered Nurse) confirmed that R5's Physician order for R5 to get an MRI (Magnetic Resonance Imaging) in response to R5's CT results. R5's MRI of her Brain results, dated 12/29/22, document, Diffuse cerebral volume loss, advanced for the patient's stated age. No acute intracranial findings. (continued on next page)

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	146097	A. Building B. Wing	02/23/2023

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/24/23 at 12:50 p.m., V20 (Unit aide) was assisting R5 with her meal of mechanical soft Swiss steak, cheesy potatoes, carrots, cake, thin liquids, and a high calorie high protein ice cream cup. R5's Physician's orders, dated 11/22, document that on 11/7/22 R5's physician ordered a cookie swallow due to R5's difficulty swallowing. On 2/1/23 at 12:25 p.m., R5 was served pureed pulled pork, macaroni and cheese, pureed beets, chocolate pudding and nectar thick liquids. V8 (Certified Nursing Assistant/CNA) was coming from the kitchen with pureed peanut butter and jelly sandwich. V8 stated, (R5) went for a swallow study today and they changed her diet to pureed and nectar thick liquids. On 2/1/23 at 1:30 p.m., V6 (CNA) stated, I received (R5's) referral for a cookie swallow from an order on 12/7/22. She had the cookie swallow done today (2/1/23). Her MRI on 12/29/22 was from a referral after she had her CT scan done in July. V6 confirmed that R5's MRI was not completed until 12/29/22.

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	146097	A. Building B. Wing	02/23/2023

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 33960 Based on observation, interview, and record review, the facility failed to provide a nutritive substitution for each meal. This had the potential to affect all 116 residents residing in the facility. Findings include: The facility's Meal Alternatives policy, dated 4/17, documents, It is the policy of the facility to provide appropriate alternates to those residents who dislike or do not eat the main entree and vegetables to help ensure adequate nutritional intake. An appropriate entree and vegetable alternate is prepared and readily available at meals. The alternate may be provided to a resident who dislikes the main entree and vegetable and may also be offered to a resident who has not consumed at least fifty percent of their entree and vegetable at the meal. Other dining options may be available as well; such as, but not limited to, an 'Always Available' menu, buffet or restaurant style menu. If a resident refuses the original entree and/or the alternate, the nurse shall be informed. Refusal to eat or poor intake should be documented in the resident's medical record. A handwritten document, no date and provided by V28 (Dietary Manager) on 2/1/23 at 1:00 p.m., documents, Our current substitutions for the main entree are: Grilled cheese sandwich, deli meat sandwich, peanut butter and jelly sandwich. The facility Resident Council minutes, dated 11/15/22, document, Dietary: Would like more meat in general. The facility Resident Council minutes, dated 12/13/22, document, Dietary: Would like to have grilled cheese with meat. The facility Resident Council minutes, dated 1/10/23, document, Dietary: Nutrition is horrible. Leaving table hungry. Portions are too small. On 1/30/22 at 12:10 p.m., R16 was yelling at V28 (Dietary manager) as she was leaving the dining room. R16 stated, They are not serving me the right food as what I'm supposed to have. I'm allergic to pork and when we have pork all I can get is peanut butter and jelly, meat sandwich that always has ham on it, or a grilled cheese. Today is baked ham, potatoes, carrots, bread, and fruit. I can't have pork so obviously I can't have the ham, and what do you think they offered me. They want to give me a grilled cheese. Really, I need protein, not the carbohydrates of the bread and the potatoes. I don't think that I'm getting enough protein when I have to get the substitute. It seems like all I eat is peanut butter and jelly because I feel like it's got the most protein out of all of my options. V28 was present and confirmed that lunch for that day was baked ham. V28 stated she has worked as dietary manager since November and the meal substitutes have always been peanut butter and jelly, grilled cheese, and deli meat sandwiches. V28 stated, These are the only substitutes that we have for each meal. I have a substitute menu from the dietician, but I haven't instituted it yet. I'm not sure if the substitutes have the same amount of actual protein as the protein I served. (continued on next page)

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	146097	A. Building B. Wing	02/23/2023

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R16's Physician's orders, dated 1/23, document a diet order for low carbohydrates and high protein, no fish, oranges, or pork. On 1/31/23 at 12:59 pm, R3 stated the facility is not following their menus. R3 stated, There are times when I will only get a sandwich for dinner, peanut butter and jelly or grilled cheese. Also, those are the only (substitutions) they offer. The only reason we had two real meal choices today and yesterday is because State is in the building. The other thing they do is use the same meat for meals all week. Such as pork. Say on a Monday they will make pork roast, Tuesday they will have pork stew and Wednesday they will have BBQ pork. The facility's Week at a Glance Week 4, dated 1/29/23, documents that four of the fourteen meals served for the week's lunch and dinner are made of pork including, pork chop stuffing bake for lunch on Sunday, baked ham for lunch on Monday, pulled pork macaroni and cheese for lunch on Wednesday, and country style BBQ ribs for dinner on Saturday. On 2/1/23 at 12:50 p.m., the facility residents were served pulled pork macaroni and cheese, beets, butternut squash, and pudding. On 2/2/23 at 12:50 p.m., V40 (Registered Dietician) stated, I have provided the facility with a substitution menu and discussed it just last month with (V28). On 2/04/23 at 11:10 am, V32 (Registered Nurse) stated, The food they serve is horrible. Sometimes residents will just get a peanut butter and jelly or bologna sandwich for a meal. The facility's CMS (Centers for Medicare and Medicaid Services) Resident Census and Conditions of Residents Form 672, dated 1/24/23 and signed by V1 (Administrator in Training), documents that 116 residents reside in the facility.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. 33960 Based on observation, interview, and record review, the facility failed to serve physician ordered therapeutic diets for three of four residents (R5, R8, R16) reviewed for therapeutic diets in the sample of 25. Findings include: The facility's Therapeutic & Mechanically Altered Diets policy, dated 4/06, documents, It is the policy of the facility that therapeutic and mechanically altered diets are ordered by the physician and planned by the dietician. A therapeutic diet is a diet ordered to manage problematic health conditions. Examples include caloric specific, low-salt, low-fat, low lactose, no sugar added, and supplements during meals. The policy also documents, A physician's order is written for all diets including therapeutic and mechanically altered diets. All physician ordered diets are planned in writing. Portion sizes are evident for each item on the menu extensions. The facility prepares and serves all therapeutic and mechanically altered diets as planned. 1. R5's Physician's orders, dated 1/23, document that R5 has an order to receive a high calorie high protein supplement shake three times a day and high calorie high protein ice cream at lunch. On 1/24/23 at 12:50, V20 (Unit aide) was assisting R5 with her meal of mechanical soft Swiss steak, cheesy potatoes, carrots, cake, and a high calorie high protein ice cream cup magic cup. V20 confirmed that R5 did not have a high calorie high protein shake. On 1/25/23 at 12:10 pm, V18 (Certified Nursing Assistant/CNA) was assisting R5 with her meal of grilled cheese, mashed potatoes, mixed fruit, yogurt, apple juice, and orange juice. R5 was not served a high calorie high protein shake or high calorie high protein ice cream cup as confirmed by V18. On 1/26/23 at 112:20 p.m., V17 (CNA) was assisting R5 with her meal of a grilled cheese, chocolate oatmeal pie, and yogurt. R5 was not served a high calorie high protein shake or high calorie high protein ice cream cup as confirmed by V17. On 2/1/23 at 12:25 p.m., R5 was served pureed macaroni and cheese and pork, pureed beets, chocolate pudding and nectar thick liquids. V8 (CNA) was coming from the kitchen with a pureed peanut butter and jelly sandwich for R5. R5 was not served a high calorie high protein shake or high calorie high protein ice cream cup as confirmed by V8. 2. R8's Physician's orders, dated 1/23, document the following orders: Diet: Regular, pureed meats, thin liquids, lactose intolerant, double portions. R8's Diet order form, dated 1/3/23, documents, Diet consistency: Mechanical soft, Pureed (meat only), double portions. On 1/24/23 at 12:54 pm, R8 was alert sitting in the dining room feeding herself mechanical soft Swiss steak, cheesy potatoes, carrots, and cake. (continued on next page)

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	146097	A. Building B. Wing	02/23/2023

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/1/23 at 12:50 p.m., R8 was served pulled pork macaroni and cheese, beets, butternut squash, and pudding. A dietary card sitting on table with R8's name on it states, Double portions pureed meat. At 12:55 p. m., V28 (Dietary Manager) confirmed that R8's card did state double portions and pureed meat, but R8 was served mechanical soft meat. V28 also confirmed that the portions on R8's plate were not double portions. R8's Current Care plan, dated 7/15/22, has no documentation of a comprehensive care plan addressing R8's dietary needs. 3. R16's Physician's orders, dated 1/23, documents a diet order for R16 of low carbohydrates and high protein, no fish, oranges, or pork. R16's Care plan, dated 6/9/22, documents, R16 in need of restriction of nutrition in form of calories/carbohydrates (salt, calories, fat, cholesterol, protein, nuts, etc.) related diagnosis/condition: Obesity, Crohn's disease. Other risk factors: Fibromyalgia, IBS (Irritable Bowel Syndrome). Interventions: Serve diet with restrictions ordered. On 1/30/23 at 12:10 p.m., R16 stated, They are not serving me the right food as what I'm supposed to have. Today is baked ham, potatoes, carrots, bread, and fruit. I can't have pork so obviously I can't have the ham, and what do you think they offered me. They want to give me a grilled cheese. Really, I need protein not the carbohydrates of the bread and the potatoes. I don't think that I'm getting enough protein. On 1/30/23 at 12:10 p.m., V28 (Dietary Manager) was present with R16 and confirmed that lunch for that day was baked ham. V28 stated she has worked as dietary manager since November and the meal substitutes have always been peanut butter and jelly, grilled cheese, and deli meat sandwiches. V28 stated, These are the only substitutes that we have for each meal. I'm not sure if the substitutes have the same amount of actual protein as the protein I served. On 2/1/23 at 2:25 p.m., V28 stated, (R16) has a high protein low carbohydrate diet. I don't follow any specific diet for her. I just try to give her extra of whatever the protein is that we are serving. On 2/2/23 at 12:50 p.m., V40 (Registered Dietician) stated, If a resident is high protein low carbohydrate then the facility would follow the CCD (carbohydrate conscious diet) diet and add an extra protein at breakfast or double protein at meals.

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	02/23/2023

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 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 23028 Based on observation, interview and record review, the facility Administration failed ensure a safe living environment and quality care and services were provided to all residents, failed to provide leadership and institute their Abuse Prevention program and failed to have an effective, comprehensive approach to numerous significant resident concerns regarding the quality of resident life within the facility. The facility has been unable to maintain consistent Administrative leadership over the last 12 months. V1 (Administrator in Training) failed to respond to resident allegations of abuse, neglect and mistreatment. Cross reference to F600, F610 and F692 (Identified Immediate Jeopardies) and additional findings at F584, F607, F609, F693, F741, F760 and F943. These failures have the potential to affect all 116 residents currently living in the facility. These failures resulted in an Immediate Jeopardy. While the immediacy was removed on 02/02/2023, the facility remains out of compliance at a Severity Level 2 as the facility's Quality Improvement Program monitors Resident Council Meeting Minutes, reviews ongoing resident concerns obtained from Department Managers through daily rounds with the residents, monitors for compliance with the Abatement Plan submitted, and review Abuse Allegations and Grievances. Findings include: The facility's Administrator Job description summary documents, The Administrator is responsible for managing, planning, organizing, staffing, directing, coordinating, reporting, budgeting, and the physical management of the facility, residents, and equipment in a way that the purpose of the facility shall be maintained in accordance with all establish practices, policies, laws, and applicable state regulations. The Administrator will manage and conduct the business of the facility in a manner that protects the facility license and certification at all times. The major goal of the Administrator is to provide an atmosphere, in which residents may achieve their highest physical, mental, and social well-being. The job description summary further documents Responsibilities: 1. Operate a facility in compliance with all federal and state, rules, and regulations; 2. Operate the facility in accordance with establish policies and procedures; 3. Assist in developing and establishing a budget, and managing within it; 4. Appoint a Director of nursing and other department heads; 5. Supervise department heads; 6. Assure, proper facility and department operation through the implementation of the specified quality assurance program. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	A second Administrator Job description provided by the facility documents Job Summary: The Administrator is responsible for directing day-to-day functions of the facility in accordance with current federal, state, and local standards, guidelines and regulations that govern long-term care facilities to ensure that appropriate care is provided to the residents in the facility. The administrator is responsible for delegating the administrative authority, responsibility necessary for carrying out the assigned duties. Job Relationships: works effectively and maintains a cooperative, working relationship with members of the regional team, Department heads, government agencies, personnel, visitors, family members, staff, and residents. The Administrator's Job description, further documents under Resident rights: 1. Maintain confidentiality of all resident information. 2. Ensure that the residence rights to fair and equitable treatment, self-determination, individuality, privacy, property, and civil rights, including the right to wage complaints are well established and maintained at all times. 3. Resident complaints and grievances and make written reports of actions taken. 4. Review and respond to resident/family council concerns as needed. The Facility Assessment, last updated on April 20, 2021, documents We are dedicated to assisting the elderly population in maintaining the highest possible quality of life, for the longest possible time. We are committed to providing an environment where the dignity of each individual is assured. We believe that a person is unique, deserving of dignity and respect. That each person possesses unique qualities which make up distinct personality. Although a person may lose the ability to function, as before, that person still possesses, this unique quality, which must be recognized and respected. That all aspects of a person must be considered: physical, mental, spiritual, and social, when assessing and providing care for all individuals, the staff must be accessible, perceptive and open to recognize needs and provide care for residence. That involvement with significance of others is beneficial to residents, family members, and staff in planning and providing quality care. During the last 12 months, the facility has been cited by the State Agency at F835 on 2/10/22 and 10/30/22 for lack of effective Administrative leadership. Upon entering the facility on 1/24/23 at 9:15 am, V1 (Administrator in Training) introduced V2 as her Assistant Administrator in Training and V3 (Licensed Practical Nurse/Resident Care Coordinator) as her Acting DON (Director of Nursing). V1 indicated this was the facility's current Administrative Staff. V31's (Vice President of Business Development and Strategy/Regional Director of Operations) Nursing Home Administrator's license is hanging on the wall of the facility. On 1/25/23 at 11:25 am, V1 stated she started as the facility's Administrator in Training under V31's (Vice President of Business Development and Strategy/Regional Director of Operations) Administrator's License on 8/22/22. V1 stated she stated she has the paperwork to apply for her Temporary Administrator License, but that documentation has not been submitted at of this time. V1 stated her testing date to become a Licensed Nursing Home Administrator is currently unknown. On 2/09/23 at 3:56 pm, V1 confirmed that V43 was the previous Administrator in Training (not a licensed) over the building, and he held that position from 2/16/21 - 7/15/22. According to record review and interviews, Administration failed to effectively act upon the following events regarding quality of care, quality of life and resident abuse: (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	1. Administration failed ensure all staff received necessary education and training. The following staff stated they had not received education on the Abuse Prevention Program since they began employment at the facility: V16 (Activities Director), V4 (Social Services), V25 (Licensed Practical Nurse), V21 (Unit Aide), V9 (Unit Aide), V18 (Certified Nursing Assistant), V34 (Unit Aide), V5 (Certified Nursing Assistant), V33 (Certified Nursing Assistant), and V23 (Housekeeper). Additionally, V1 confirmed the facility has not provided any education or training for new staff on managing residents with behavioral health needs. This includes: V2 (Assistant Administrator in Training), V3 (Resident Care Coordinator/Licensed Practical Nurse), V11 (Licensed Practical Nurse), V51 (Licensed Practical Nurse), V52 (Registered Nurse), V53 (Registered Nurse), V7 (Registered Nurse), V54, V63, V33, V64, V65, V19 (all Certified Nursing Assistants), V34, V55, V9, V35, V56, V57, V58 (all Unit Aides), V59 (Transportation Aide), V15 (Social Service), V14, (Social Service), V60 (Activities Aide) and V61 (Activities Aide), as cited at F943 and F741. 2. Administration failed to acknowledge, immediately report, and investigate allegations of verbal abuse, sexual abuse, and misappropriation, brought forth by residents of the facility during a Resident Council Meeting (1/10/23) in which V1 and V2 were present for, as cited at F600, F607, F609 and F610. 3. Administration failed to recognize that R9 was to be on 1:1 supervision when out of his room, per his Plan of Care, due to a history of sexually inappropriate behavior towards others, as cited at F600. This failure allowed R9 to have unsupervised access to female residents. R6 reported on 1/05/23, R9 had touched her sexually. R6, R11 and R13 reported on 1/10/23, R9 had touched them in a sexually inappropriate manner. 4. Administration failed to respond to numerous grievances and concerns voiced by residents during Resident Council (1/10/2023), affecting the quality of care and quality of life of those living in the facility, as cited at F584, F585, and F600. 5. Administration failed to recognize that R6, who has a State appointed Guardian, lacked the mental capacity to consent to known ongoing sexual relationship with R15, as cited at F600 and F610. 6. On 1/25/23 and 1/26/23, the State Surveyors discussed with V1 and V2 the following concerns regarding abuse within the facility: a.) R6 reported to V4 on 1/05/23 that R9 was touching her sexually. b.) R6, R11 and R13 reported in the January 10, 2023, Resident Council Meeting that R9 had touched them sexually, which was confirmed by V10 (Ombudsman). c.) R3 reported to V1, on 1/16/23, verbal abuse by V3. V10 reported R3's same allegation of abuse to V1 again, on 1/19/23, along with an allegation of physical abuse by V27 (Licensed Practical Nurse). d.) R1 was found to have suspicious inner thigh bruising of unknown origin when admitted to the hospital on 1/17/23, which was reported to the facility by hospital staff. e.) On 1/24/23, R5 had visible eye bruising of unknown origin, reportedly present for 2-3 days. At the time these concerns were originally discussed with V1 and V2, they had not been investigated or reported to the State Agency per the facility's Abuse Prevention Program. Upon returning to the facility on [DATE], V1 had yet to implement their Abuse Prevention Program regarding these allegations by initiating abuse investigations and suspending staff suspected of abuse, as cited at F607, F609 and F610. (continued on next page)

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	146097	A. Building B. Wing	02/23/2023

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	7. Administration failed to ensure that R20, who is nonverbal and depends on enteral nutrition, received gastrostomy tube (g-tube) feedings for adequate nutritional intake and implement dietician recommendations to prevent significant weight loss. R20 went nine days without receiving any type of nutritional intake causing her emotional/psychological distress as well as pain related to hunger pains. R20 has also lost 20 lbs (11.4% weight loss) since R20 was admitted on [DATE] (five months). On 1/26/23 at 8:15 am, V10 (Ombudsman) stated, I'm in the building frequently, not as often as I'd like. At least 1-2 times per week. I come in and (V1's) door is always closed. If I go to (V1) with concerns she never acts on them. I've gone to her with abuse concerns that she doesn't look into. V10 went on to explain about an allegation of verbal and physical abuse she received from R3 on 1/19/23, that she spoke to V1 about that day. V10 stated she informed V1 that R3 told her V27 (LPN) would hit him in the leg when she passes his medication, and that V3 verbally abused him a few days prior. V10 stated V1 was not concerned with the allegations made and indicated that she had already discussed the situation with V27 and V3's behavior towards R3; however, V10 stated, I've discussed abuse concerns with (V1 before), but she doesn't act on them like she should. I'm concerned it wasn't reported or investigated as it should have been. V10 stated residents complain about the way V3 and V8 (Certified Nursing Assistant) speak to them, and she stated she has witnessed (V8) blow off medical concerns. V10 stated she was present for the 1/10/23 Resident Council Meeting, and V1 and V2 were in attendance, as they had been invited due to numerous resident concerns. V10 stated R2 (Resident Council [NAME] President) was voicing most of the concerns and other residents were agreeing with him. V10 stated some of the allegations made during the meeting were abusive in nature. V10 stated it was alleged that (V3) would take resident medications home with her. V10 stated R16 complained about staff not administering her pain medications. V10 stated residents complained of staff retaliating when they complain about something, like staff will be mean to them, make fun of residents, and yell at them. During the meeting, V10 stated she heard concerns about residents being yelled at by CNAs, nursing staff not doing their medication passes, giving medications late, and doubling up on medication passes. V10 stated, As soon as the State cleared the facility in November from their Annual Survey, everything changed back to how it previously was. When the facility was trying to get back into compliance, residents were happier, and Administration was responsive to my concerns. Residents felt like they could go to Administration at that time. But, since November, things have greatly changed. I will bring concerns to (V1), who acts like she cares but never acts on my issues. (V1) stands up for her employees, not the residents. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 2/04/23 at 11:10 am, V32 (Registered Nurse) stated she has been working as an Agency Nurse at the facility for several months now. V32 stated, Management is poor, and nothing gets done. V32 stated V1 will remove documentation from resident records and tell staff not to chart resident incidents, altercations, or elopements. V32 stated she had V1 tell her just last month not to document that R21 had eloped from the facility and had to be brought back by a member of the community that found her. V32 stated R6 and R15 have been caught having sex in their rooms and staff have been instructed by V1 to not let R6 in R15's room. V32 stated R9 has been taken off 1:1 monitoring for inappropriate sexual behaviors, because the facility didn't have the staff to constantly monitor him. V32 stated this even happened after State cited us for abuse (involving) R9 in 2022. V32 stated everyone, including V1, was aware that R6 had alleged sexual abuse by R9 on 1/05/23. V32 stated she texted V1 a few days after R6's allegation (1/05/23) was made, because R9 was being sexually inappropriate with R14, and V1 got upset with her for notifying her of the situation. V32 stated she has witnessed V3 yell at R3. V32 stated narcotics were reported missing about two months ago, but it was not investigated as diversion. V32 stated V3 will prep her medication prior to her medication pass, by putting the resident's pills in a cup so V32 can just hand them out to the resident. V32 stated she knows this is not proper practice, but it is how the medication is routinely handled. V32 stated she has noticed at times resident's that are to be receiving narcotics, the narcotic is not always in the cup prepped by V3. V32 stated, I have caught staff sleeping at night on third shift. I took pictures and sent them to (V1), but nothing happened to the staff. V32 indicated she has witnessed staff that are to be providing 1:1 supervision for resident watching movies/videos on their phone, especially at night. V32 stated new staff receive no training on how to handle the mentally ill population or abuse, and they have high school students providing 1:1 supervision at night, who have zero training. V32 stated V27 will hide in V3's office when she is supposed to be working on the floor. V32 indicated she has come on shift to find that V27 had not given R20 her bolus tube feedings or medications. V32 stated, I just told the Agency I couldn't work there anymore; residents are not taken care of, and there is such poor management in that building. On 2/02/23 at 1:59 pm, V4 (Social Services) stated she left her position on 2/24/23, because Administration was being extremely hostile to me after talking to you (State Surveyors). It was a very uncomfortable situation. V4 stated she came into her role in Social Services with no training from the facility on what her job was, what constituted abuse, or how to deal with the mentally ill population. V4 stated that V1 has known about R9's sexual behaviors. V4 stated R9 was openly discussed in the Morning Meeting with all of the Department Heads on 1/06/23. V4 stated they specifically discussed in that meeting, R9 going in and out of resident rooms at night, and that R6 reported R9 touched her sexually the day prior. V4 stated, at that time, it was suggested by the team that R9 go back on 1:1 supervision or they find placement for him elsewhere. V6 stated she recalls the discussion about placing R9 on 1:1 supervision, because Management didn't want things to escalate to a reportable incident. V4 stated the Social Service staff had also talked to both R6 and R15's family regarding their sexual relationship in December 2022. V4 stated V1 was fully aware of the situation, but V1 felt R6 and R15 had a high enough BIMS (Brief Interview for Mental Status) that they could not stop them from engaging in sex. V4 stated V1 spoke to both R6 and R15's families about their sexual relationship. The CMS-672 (Resident Census and Conditions of Residents), dated 1/24/23 and signed by V1 (Administrator in Training), documents 116 residents currently live in the facility. The Immediate Jeopardy began on 12/15/22 when R9 was removed from 1:1 supervision, giving R9 the opportunity to commit sexual and verbal abuse to female residents. (continued on next page)

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	146097	A. Building B. Wing	02/23/2023

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	V1 (Administrator in Training) and V2 (Assistant Administrator in Training) were notified of the Immediate Jeopardy regarding R9 on 1/30/23 at 9:22 a.m. The facility submitted the original Abatement Plan to the State Agency on 1/31/23. A revision was requested and the final amended Abatement Plan was submitted on 2/01/23. The surveyor confirmed through interview and record review that the facility took the following actions to remove the Immediate Jeopardy: 1. A Director of Nursing (V48) was hired and started 1/31/23. 2. V1 qualifies to be a LNHA (Licensed Nursing Home Administrator), has completed all portions of the application for Licensure with the IDFPR (Department of Professional Regulation), and her application was mailed 1/31/23. 3. V2 and V48 have mailed their applications to receive a temporary Administrator's License, so they can test to become a LNHA. 4. On 1/30/23, Regional Director of Operations in-serviced V1 on the Facility's Abuse Prevention Program, Abuse Occurrence Investigations form, CMS Abuse Critical element Pathway, Resident Rights, Injuries of Unknown Origin, QAA Policies and Processes and Resident Grievance/Complaint policies. 5. On 3/02/23, V1 is scheduled to attend LNHA training conference, provided by several members of the facility's Governing Body, contracted leaders, Regional Director of Operations,Regional Director of Clinical Operations and Wound Care Specialist. 6. Regional Team Members will be on site at minimum 3 days each week to monitor for continued compliance and training of Administration Team Members. 7. V49 (Serious Mental Illness Expert in Long Term Care) will consult with the facility quarterly, until deemed unnecessary. 8. V10 (Ombudsman) has been contacted to hold in-service on abuse with facility staff.

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	146097	A. Building B. Wing	02/23/2023

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 23028 Based on observation, interview and record review the Governing Body failed to be consistently involved in the management and operation of the facility, failed to implement policies related to facility operations and resident care, including Abuse Prevention, Significant Weight Loss, Processing of Physician's Orders, and staff education and training. The Governing Body failed to ensure Director of Nursing's responsibilities were completed. This failure has the potential to affect all 116 residents residing in the facility. Cross reference to F600, F610 and F692 (Identified Immediate Jeopardies) and additional findings at F584, F607, F609, F693, F741, F770, F760, F776, F808, F835 and F943. These failures have the potential to affect all 116 residents currently living in the facility. Findings include: Upon entering the facility on 1/24/23 at 9:15 am, V1 (Administrator in Training) introduced V2 as her Assistant Administrator in Training and V3 (Licensed Practical Nurse/Resident Care Coordinator) as her Acting DON (Director of Nursing). V1 indicated this was the facility's current Administrative Staff. V31's (Vice President of Business Development and Strategy/Regional Director of Operations) Nursing Home Administrator's license is hanging on the wall of the facility. On 1/25/23 at 11:25 am, V1 stated she started as the facility's Administrator in Training under V31's (Vice President of Business Development and Strategy/Regional Director of Operations) Administrator's License on 8/22/22. Additionally, V1 stated the facility has not had someone in the position of DON for a length of time, but V3 has been filling in until the new DON can start. V1 stated V31 is in the facility occasionally, and V31 and V42 (Regional Nurse) are who she is to seek corporate support from. On 2/23/23 at 11:36 am, V1 was questioned who comprised the facility's Governing Body. V1 stated, What is that? and a brief explanation of Governing Body within a Long-Term Care Facility was given. After that, V1 stated she didn't know who their Governing Body consisted of, and she would reach out to her corporate support for more information. At 12:30 pm, V1 presented the Corporate Compliance and Ethics Program Overview Policy and stated she was advised the individuals that are identified on that policy are who make up the facility's Governing Body (V66, V67, V68, V69, V70, V71, V72, V73). (continued on next page)

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	146097	A. Building B. Wing	02/23/2023

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's Corporate Compliance & Ethics Program Overview (5/2021) documents [NAME] Health Care's management staff (Directors, Regionals' and Administrators') are responsible for monitoring the compliance and ethics program. The Corporate Compliance & Ethics Program was reviewed, and the Code of Conduct was revised and distributed to all employees. [NAME] Health Care Operation and Nursing Policies and Procedures are in place and cover areas related to Corporate Compliance and Ethics. A Mandatory In-service List is provided to all Administrators to ensure education is conducted at least annually. Regional Directors conduct audits throughout the year during visits on areas of risk as identified. The Regional Teams and others identified by the Regional Teams conduct mock surveys annually. External Audits are conducted periodically. The following documents are incorporated within the Corporate Compliance and Ethics Program. This list is not all inclusive: Operational Policies and Procedures; Nursing Policies and Procedures; New Administrator Training Manual; New DON (Director of Nursing) Training Manual, Resident Admissions Packet, SWAT Programs; Quality Improvement Programs, Quality Assessment and Assurance Committee Policy Abuse Prevention Program, Employee Handbook, Employee and Resident Satisfaction Surveys, Equal Employment Opportunity policy False Claims, Whistle Blower & Drug Free Workplace Policy. 1. On 1/24/23 at 12:10 pm, concerns regarding allegations of staff to resident abuse, made by R3 against V3 and V27 (Licensed Practical Nurse), were discussed with V1 at length. V1 was aware of these concerns, as they had been previously reported to her by R3 and V10 (Ombudsman), on 1/19/23, and V1 failed to implement the facility's Abuse Prevention Program at that time. On 1/25/23 at 12:59 pm, the above-mentioned concerns and a continued lack of a thorough investigation was discussed further with V1 and V2. Additionally, concerns regarding allegations of sexual abuse, made by R6 towards R9 on 1/05/23, numerous allegations of verbal, sexual abuse, staff retaliation against residents and narcotic theft voiced by residents during Resident Council on 1/10/23, and injuries of unknown origin (R1 and R5) that had not been investigated, were discussed with V1 and V2 at that time. During that interview, V1 stated she was aware that there were numerous issues brought forth that were concerning. V1 indicated she was trying to see what her Department Heads could do to resolve some of the concerns. V1 was questioned if she had reached out to V31 regarding these specific issues and V1 indicated she had yet to do so. On 1/30/23 at 9:17 am, V1 stated the only investigations she had initiated or reported to the State Agency, since the Survey Team arrived on 1/24/23, was R1's injury of unknown origin that was brought to V1's attention on 1/25/23. This meant V1 had still failed to implement the facility's Abuse Prevention Program regarding the additional abuse allegations that were discussed on 1/25/23. V1 stated at that time, she had reached out to her Regional Advisor (V42) over the weekend for guidance, but she had not discussed the concerns with V31. Cross reference findings at F584, F600, F607, F609, F610, F741, F835 and F943. F600 and F610 was cited at the Immediate Jeopardy Level as a result of the Governing Body's lack of involvement and oversight of the facility's Abuse Prevention Program. 2. The Facility's Director of Nursing job description (no date) documents, Job Summary: To plan, organize, develop and direct the overall operation of our Nursing Service Department in accordance with current federal, state and local standards, guidelines, and regulations that govern our facility and as may be directed by the Administrator and the Medical Director to ensure that the highest degree of quality care is maintained at all times. (continued on next page)

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	146097	A. Building B. Wing	02/23/2023

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 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/01/23 at 9:58 am, V3 (Licensed Practical Nurse/Resident Care Coordinator) clarified that she was only hired in (on 10/17/22) as an RCC (Resident Care Coordinator) and that she does the scheduling of nursing staff, but has not been doing any actual DON duties, such as oversite of Physician's Orders or resident care delivered by the licensed nursing staff and CNAs (Certified Nursing Assistants). V3 was questioned about her lack of involvement in the operations of the Nursing Services Department, as she had been identified and introduced at the start of the survey as the Acting DON. V3 reiterated that was not her role. On 2/7/23 at 4:10 pm, V41 (Medical Director) agreed during interview that the facility has had issues procession physician's orders correctly. V41 stated, The DON should be overseeing these things and making sure they are followed through with. However, I know they haven't had a DON for a while. During the survey, numerous issues regarding the processing of Physician's Orders for medication, diagnostic testing, dietary orders, weight monitoring and the delivery of Parenteral nutrition have been identified. Cross reference findings at F692, F693, F770, F776, and F808. F692 was cited at the Immediate Jeopardy Level and F693 at a harm level as a result of the Governing Body's lack of involvement in the operation of the facility's Nursing Service Department. The facility's CMS (Centers for Medicare and Medicaid Services) Resident Census and Conditions of Residents Form 672, dated 1/24/23 and signed by V1, documents that 116 residents reside in the facility.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 23028 Based on interview and record review, the facility failed to ensure resident records documented significant events that resulted in residents being transferred out of the facility, for two of nine residents (R2, R6) reviewed for accuracy of medical records, in a sample of 25. Findings include: The facility's policy, titled Nursing Documentation Guidelines advises nursing staff to chart the following, Behavior/Orientation Documentation: 1. Any changes in the resident's behavior or level of orientation. 2. Chart only objective terms, only the facts. 3. Description of symptoms. Document the resident's exact behavior. Accident/Incident Documentation: 1. The circumstances surrounding the accident/incident. 2. Where the accident/incident took place. 3. Date and time the accident occurred. 4. Name of witnesses and their account of the accident/incident. 5. The time physician was notified and what was ordered, if applicable. 6. The date and time the family was notified, if applicable. 7. The condition of the resident, including vital signs. 8. Disposition of the resident (i.e. transferred to hospital, put to bed, x-rays, neuro checks, etc.). 9. All pertinent observations. 10. Every shift documentation for 72 hours after the accident/incident occurred. 11. Date, time, signature, and title of person recording the data. 1. On 1/24/23 at 2:48 pm, V1 (Administrator in Training) stated just yesterday (1/23/23), R6 had been upset with her parents, got mad and just walked out of the facility in the presence of staff. V2 (Administrative Assistant in Training) immediately walked out with R6 and was following her. V1 stated she and V3 (Licensed Practical Nurse), V6 (Certified Nursing Assistant) and V7 (Registered Nurse) also went outside to follow R6 and try to redirect her back to the building. V1 stated R6 walked about four blocks as they followed and then ran into a field, took off all her clothes, grabbing loose grocery bags that were laying on the ground and threatened to hang herself with them. R6 then ran to the cemetery. V1 stated when they could not get R6 to comply with putting on her clothes and returning to the facility, they called an ambulance to take her to the local hospital, where she is currently admitted . V1 stated R6 was outside for approximately 30 minutes. R6's medical record contains no documentation of this incident. The last documented Nursing Note is dated 1/23/23 at 9:30 am, No adverse reactions from medication change. Able to focus on conversations briefly and express her needs. Ambulates in facility with steady gait. 2. On 1/24/23 at 12:10 pm, V1 stated R2 had attempted to sexually assault a Certified Nursing Assistant (V5) on 1/14/23. According to V1, who was not in the facility at the time of the incident, V5 called the police to report what R2 had done to her and R2 was arrested and charged with attempted sexual assault. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/31/23 at 1:45 pm, V30 (Police Officer) stated he was R2's arresting officer on 1/14/23. V30 stated he responded to a 911 call at the facility. V5 told him that R2 pulled her pants down and then pulled his pants down. R2 then pulled V5 in close, putting his penis between her legs. V5 indicated she distracted R2, and she got away. According to V30, R2 denied the assault and said all he did was hug V5 in his room. V30 confirmed that R2 is currently in jail and awaiting to appear before the Judge. R2's medical record was reviewed and contained no documentation of the alleged event, or that R2 had been taken from the facility and placed in jail. The last documented Nurse's Note, was on 1/14/23, which is (R2) returned to facility from (home visit).

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 23028 Based on interview and record review, the facility failed to provide education and training to all staff on Abuse and Neglect. This failure has the potential to affect all 116 residents that currently live in the facility. Findings include: The Abuse Prevention Policy (revised 11/28/2016), documents, During orientation of new employees, the facility will cover at least the following topics: Sensitivity to resident rights and resident needs; Staff obligations to prevent and to immediately report abuse, neglect, exploitation, and theft (misappropriation of resident property) to supervisory personnel and administrator; and how to distinguish theft from lost items and willful abuse from insensitive staff actions that should be corrected through counseling and additional training; Dementia management and resident abuse preventions; Including, How to assess, prevent and manage aggressive, violent and/or catastrophic reactions of residents in a way that protects both residents and staff; and, How to recognize and deal with burnout, frustration, and stress that may lead to inappropriate responses or abusive reactions to residents. Prohibition against staff using any type of equipment (e.g., cameras, smart phones, and other electronic devices) to take, keep or distribute photographs and recordings of residents that are demeaning or humiliating. Annually, each covered individual will receive a review of the above topics. Annually, supervisory personnel will receive training on their obligations under law when receiving an allegation of abuse, neglect, exploitation or theft, and how to monitor and correct inappropriate or insensitive staff actions, words or body language. The Facility Assessment, which was last updated on April 20, 2021, documents, (Staff) Education needs to begin at employment. General training topics: Communication - effective communications for direct care staff. Resident's rights and facility responsibilities - ensure that staff members are educated on the rights of the residents and the responsibilities of a fallibility to properly care for its residents; Abuse, neglect, and exploitation - Training that at a minimum educates staff on activities that constitute abuse, neglect, exploitation, and misappropriation of resident property; procedures for reporting incidence of abuse, neglect, exploitation, or the misappropriation of resident property; and care/management for persons with dementia, and resident abuse prevention. On 1/24/23 at 3:45 pm, V16 (Activities Director) stated, I never received any kind of abuse training when I started in August or since then. On 1/24/23 at 3:15 pm V4 (Social Services) stated she was hired in October 2022 but has received no Abuse training since she started. On 1/25/22 at 10:50 a.m., V25 (Licensed Practical Nurse) stated, I've been working here since September as agency (staff). The facility hasn't provided me with any abuse training. I just use past knowledge from other facilities. I'm not sure who the Abuse Coordinator is. I would report abuse to (V1/Administrator in Training) I assume, since she is the Administrator. At least that's what I do in other facilities. (continued on next page)

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 1/25/23 at 10:30 a.m., V21 (Unit Aide) stated, I didn't get any formal training (on abuse). I'm not sure who the abuse coordinator is. If I witness abuse, I go to social services immediately. On 1/25/23 at 10:14 am, V9 (Unit Aide) stated she has worked at the facility since November 2022. V9 stated she does not know who the abuse coordinator is, and she did not receive any training on abuse when she started. V9 indicated she has had some training on Abuse with other employers in the past, but not with this facility. On 1/25/22 at 10:05 am, V18 (Certified Nursing Assistant), I've worked here for 6 months. I had some kind of abuse training done, but I'm not sure who the abuse coordinator is. If I witnessed abuse, I'd report it to the nurse. On 1/25/23 at 10:20 a.m., V23 (Housekeeper) stated, I've worked here for 5 months. I went over abuse paperwork on my own when I started. I don't know who the abuse coordinator is, and I don't know for sure who to report abuse to. On 2/01/23 at 5:10 pm, V34 (Unit Aide) stated he has worked at the facility since November 2022 and did not receive any training on Abuse when he was hired. On 2/01/23 at 5:45 pm, V5 (Certified Nursing Assistant) stated she has worked for the facility since September 2022 and had not received any kind of abuse prevention training, until 1/30/23. On 2/02/23 at 10:25 am, V33 (Certified Nursing Assistant) she did receive training on abuse, on 1/31/23, from administrative staff. V33 stated prior to that, she had never been trained on Abuse Prevention and reporting. On 1/25/23 at 12:59 pm, V1 stated Abuse Prevention training for all staff is the responsibility of herself and V2 (Assistant Administrator in Training). V1 stated there is no set schedule to the frequency of Abuse Prevention training, but there are to be random questions that are asked of staff as to who the abuse coordinator is and who to report to. V1 stated, upon hiring new staff, the specific Department Head or herself/V2 will do the abuse training. At that time, V1 stated she would provide the documentation to support such training, but that documentation was never given. The CMS-672 (Resident Census and Conditions of Residents), dated 1/24/23 and signed by V1 (Administrator in Training), documents 116 residents currently live in the facility.