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	05/08/2023

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 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. 23028 Based on record review and interview, the facility failed to provide individual quarterly financial statements and ensure accurate documentation of financial transactions were maintained for four of four residents (R3, R6, R9 and R10) reviewed for resident funds in a sample of 20. Findings include: The facility policy, titled Resident Funds Policy and Procedure documents The Facility Health Care recognizes the resident's right to mange his/her own financial affairs and does not require the resident to deposit their personal funds with (the) facility. However, upon written authorization of a competent resident the facility will hold, safeguard, manage and account for personal monies deposited with the facility. If the resident has been determined to be incompetent, the written authorization may be signed by the resident's fiduciary guardian, legal representative, or immediate family. All accrued interest paid to the resident monies account is prorated among those residents having personal funds in the account. In this manner, the resident will have access to his/her monies within the same day. At least quarterly, the facility will provide the resident or his/her representative a written, itemized statement of all transactions to his/her account which occurred in the last quarter. A review of the resident's account status is available to the resident upon request and in a reasonable amount of time. The policy later documents, Further, the facility will require dual signatures on all banking transactions requiring signatures as well as require receipts for all purchases made from residents' personal monies that shall include the date of purchase, amount of purchase and detail of all items or services purchased. 1. R3's Electronic Medical Record documents she has the current diagnosis of Intellectual Disabilities and V6 is listed as R3's Mother and Power of Attorney. On 5/01/23 at 12:10 pm, V6 (Power of Attorney) stated R3 was discharged from the facility on 3/17/23. V6 indicated she was not certain how much money was actually in R3's resident fund account at the time of her discharge because she has never received a financial statement from the facility for R3's account. V6 stated she was aware that R3 had taken cash withdrawals from her account since she was admitted in December of 2021, but had no documented account of exactly how much money R3 withdrew or what the money was even used for. V6 stated she was told by the facility's Business Office that they were sending a check for the remaining amount of money in R3's account, which was around $1200. V6 stated she requested an itemized statement of R3's funds at that time. V6 stated she received a check via mail from the facility in the amount of $1221.26, but no financial statement was provided. (continued on next page)

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

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R3's Trust Fund Statement documents during the last 12 months R3 took cash withdrawls from her account on the following dates, without a dual signature and/or evidence of receipt for purchase: 6/15/22 ($10), 6/22/22 ($10), 7/01/22 ($10), 7/13/22 ($10), 7/18/22 ($10), 7/20/22 ($20, $20, & $10), 8/01/22 ($10), 8/08/22 ($10), 8/12/22 ($30), 8/15/22 ($10), 8/26/22 ($20), 9/02/22 ($10), 9/09/22 ($10), 9/12/22 ($10), 9/19/22 ($10), 9/28/22 ($10), 10/03/22 ($10), 10/12/22 ($10), 10/26/22 ($10, $20 & $15), 11/02/22 ($10), 11/07/22 ($10), 11/18/22 ($10), 11/23/22 ($10), 12/14/22 ($30), 12/21/22 ($15, $15, & $15), 12/28/22 ($15), 1/04/23 ($30), 1/09/23 ($100), 1/18/23 ($15), 1/23/23 ($15), 1/27/23 ($10), 1/30/23 ($15), 1/31/23 ($30), 2/01/23 ($15), 2/06/23 ($15), 2/08/23 ($15), 2/15/23 ($30), 2/24/23 ($15), 3/08/23 ($15), 3/10/23 ($15), and 3/13/23 ($15). On 5/02/23 at 9:27 am, V7 (Business Office Manager) stated she did mail a check to V6 for the remaining money in R3's account to close it, but did not include a financial statement. 2. The Electronic Medical Record documents R9 has the diagnoses of Encephalopathy and Alcohol Abuse and has a Court Appointed State Guardian (V30). R9's Quarterly Financial Statement, beginning 2/01/23, documents R9 took cash withdrawls from her account on the following dates, without a dual signature and/or evidence of receipt for purchase: 2/15/23 ($10), 2/22/23 ($20), 2/24/23 ($20) and 3/29/23 ($10). On 5/08/23 at 8:51 am, V30 (State Appointed Guardian for R9) stated, I checked (R9's) file this morning, and I have never received a financial statement for (R9). She has been at (the facility) for about a year. I have that she moved to that facility on 5/19/22. 3. The Electronic Medical Record documents R10 has the current diagnoses of Schizoaffective Disorder and Cerebral Infarct. A Minimum Data Set assessment, dated 3/21/23, documents R10 has a current BIMS (Brief Interview of Mental Status) score of 10, indicating moderate cognitive impairment. R10's Quarterly Financial Statement, beginning 2/01/23, documents R10 took cash withdrawls from her account on the following dates, without a dual signature and/or evidence of receipt for purchase: 2/03/23 ($15), 2/08/23 ($15) and 3/06/23 ($15). 4. The Electronic Medical Record documents R6 has the current diagnosis of Chronic Paranoid Schizophrenia. A Minimum Data Set assessment, dated 3/21/23, documents R6 has a current BIMS (Brief Interview of Mental Status) score of 15, indicating no cognitive impairment. R6's Quarterly Financial Statement, beginning 2/01/23, documents R6 took cash withdrawls from her account on the following dates, without a dual signature and/or evidence of receipt for purchase: 2/01/23 ($20), 2/13/23 ($20), 2/15/23 ($20), 2/22/23 ($20), 2/27/23 ($20), 3/13/23 ($20), 3/15/23 ($20), 3/20/23 ($20), 3/22/23 ($20), 3/27/23 ($20) and 3/29/23 ($20). On 5/02/23 at 2:00 pm, R6 stated she does withdrawal money on occasion, but had not received any financial statement of the funds in her account in as long as I can remember. (continued on next page)

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/02/23 at 9:27 am, V7 (Business Office Manager) stated resident funds statements are to be mailed to responsible parties quarterly, but V7 stated her most recent common practice was to just print statements when resident's or family asked instead of mailing them routinely every three months. V7 stated she was unable to produce a record of who had requested a statement of their resident funds and/or received a copy. V7 concluded that mailing quarterly financial statements had fallen to the waste side because we are short staffed in the Business Office and it's too much for one person to do that. On 5/02/23 at 2:48 pm, V5 (Corporate Staff) concluded that the documentation associated with recent cash withdrawls from R3, R6, R9 and R10's accounts was not consistent with what was required per the facility's Resident Funds Policy. 5/02/23 12:40 pm V9 (Regional Corporate Nurse) confirmed that V7 is supposed to be sending quarterly financial statements to all residents or their responsible parties on a routine basis.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	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** 33960 Based on observation, interview, and record review, the facility failed to ensure residents were free from physical and verbal abuse by R16, a [AGE] year old independent ambulatory man, with a known history of frequent resident to resident altercations with 1:1 Staff present, failed to institute new safety interventions to protect against resident to resident altercations, failed to provide supervision to protect a resident R1, with offensive behaviors, from retaliatory physical and verbal abuse despite 1:1 supervision. These failures had the potential to affect all 118 residents residing in the facility. These failures resulted in an Immediate Jeopardy. While the immediacy was removed on 5/8/23, the facility remained out of compliance at a Severity Level 2 as the facility continues to conduct ongoing Abuse Identification and Prevention Training, protecting residents during an altercation training, and effectively providing 1:1 supervision training with all current staff, Agency Staff and newly hired staff and the Quality Improvement Program conducts random audits to ensure facility staff's compliance with resident behavior monitoring, implementing abuse interventions, staffs' understanding of what to do in a situation of an altercation and to effectively provide 1:1 supervision, and the Abuse Prevention Program. Findings include: The facility's Abuse Prevention Program, dated 11/28/16, documents, The facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, and exploitation. This facility is committed to protecting our resident 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 policy also documents, 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. 1. A Facility 5 Day Final Report, dated 4/28/23, documents, Original complaint: It was reported on 4/25/23 that while in the common areas R16 allegedly called R1 a 'b**ch' and told her she needed to go home. Residents will be offered 1:1 time with Social Services once a week for 3 weeks. A written statement signed by V19 (Business Office Manager), dated 4/25/23, documents, I was sitting in the office, on my computer. When I heard yelling in the TV room. I got up to see what was happing. (R16) was stood in front of the couch, in front of (R1). He called her a b**ch. Then, I overheard him threatening to cut (R1). As of 5/3/23, R1 nor R16's medical records have no documentation of 1:1 sessions with Social Services. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 5/2/23 at 10:00 a.m., R1 was sitting outside smoking. R1's 1:1 staff member, V17 (unit aide), was watching her through the window from inside of the facility. V17 stated, I have never witnessed a physical altercation with (R1) until today. She gets verbally aggressive a lot with other residents. Today (R1) and (R16) got verbal with each other and she started calling him a b**ch then he slapped her a few times in the face. On 5/2/23 at 1:30 p.m., R17 was observed propelling himself towards V1's Office. R17 was bleeding from his mouth and his right hand was actively bleeding. At that time R17 stated, He (R16) punched me in the mouth. All I was trying to do was help him open his ice cream. On 5/2/23 at 1:40 p.m., V13 (Social Services) stated, (R16) will walk down the hall and say stuff or come in here and if it's not taken care of right away he has an outburst. It's like something is going on with him. R17's Incident Note, dated 5/2/23 at 1:44 p.m., documents, R17 assessed with minor skin tear 0.2 cm (centimeters) x 0.2 cm to left hand and swollen bottom lip. R16's Incident note, dated 5/2/23 at 2:51 p.m., documents, R16 verbally aggressive with nurse during assessment and asking R16 about what happened. (R16) states that other resident (R17) spoke racial slurs to him so he punched him in the face. On 5/2/23 at 2:47 p.m., V18 CNA stated, I'm (R1's) 1:1 tonight. I was never told that (R1) and (R16) had an incident this morning. That would have been nice to know. I try to keep (R15) and (R16) away from (R1). (R16) is so unpredictable you never know what he's going to do. When he got in (R1's) face (4/25/23) (R16) told (R1) he was going to slice (R1). He's a little scary. (R1) likes to instigate things and get other residents upset then they want to go after her. (R16) is very hateful and gets angry with (R1) as well. He's hit her before. I don't know what to do in the case of another resident trying to hit (R1). All I know to do is to try and redirect them. I haven't had any training about these situations. I know that (R1) has spit on other residents and they've hit her. I can't believe (R16) hit (R17). (R17) is the sweetest man ever and wouldn't instigate anyone to hit him. See (R16) is unpredictable. On 5/3/23 at 12:20 p.m., V17 stated, (R1) and R16 had two incidents yesterday. The one where he slapped her across the face in the morning, and then in the afternoon they had a verbal altercation. Right after he hit her, (V1 Administrator in Training) came up on the commotion. (R16) went off on (V1). He started yelling and cussing at her. I didn't notify anyone about what happened because (V1) told me she had it all taken care of. Around 1:15 p.m., (R1) sat next to (R16). I asked her to not sit there and we could sit somewhere else, and she refused to move. She reached over and touched (R16's) hair, and he said, 'Keep your f**king hands off of me.' (R1) wouldn't move so I asked (R16) if he would move, and he told me, 'White lady you aren't going to tell me what the f**k to do.' The office door was closed when I left, so I put a note under the door to let (V2 Assistant Administrator in Training) know what happened with that incident. R1 and R16's current medical records have no documentation of abuse investigations regarding both altercations that occurred on 5/2/23. There is also no documentation of interventions implemented following each altercation to prevent R16 from further assaulting any other residents. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 5/3/23 at 11:25 a.m., V23 Registered Nurse stated, I was working yesterday when (R16) punched (R17) in the face. (R17) told me he was trying to help (R16) with opening his ice cream at lunch and (R16) said (R17) called him a racial slur. (R16's) baseline is agitated. It doesn't take much to get him worked up and he thinks everyone is against him racially. We didn't change anything supervision wise either for (R16). I had no idea that (R16) hit (R1) yesterday (5/2/23) morning. No one told me. On 5/3/23 at 11:38 a.m., R16 was ambulating independently down the hall. R16 stated, I don't know what you're talking about when asked about the 5/2/23 incident and started yelling and cussing. On 5/3/23 at 11:50 a.m., V21 Certified Nursing Assistant stated, I didn't know that (R16) and (R1) had an incident yesterday (5/2/23). He was irritable the whole day yesterday. It started even at breakfast he was antagonizing people and yelling so I took him back to his room for breakfast. Anyone that walked by him yesterday he would exchange words with them. When he got to lunch he was yelling at residents as well. He's like that today too. I came into the end of the argument yesterday. He had punched (R17). I took (R17) from the room. I'm not aware of us doing anything different with (R16). On 5/3/23 at 12:10 p.m. V22 Registered Nurse stated, I wasn't aware that (R1) and (R16) had an altercation yesterday morning and I was (R1's) nurse. V22 also stated that (R16) is able to independently ambulate throughout the entire facility. On 5/3/23 at 1pm, V13 (Social Services) stated, I didn't know that (R16) had an incident with (R1) in the morning. I knew he had two incidents in the afternoon. I never did work with him or do anything with him regarding the incidents. V13 also confirmed that she has not done any 1:1 sessions with R1 or R16 since their incident on 4/25/23. On 5/3/23 at 2pm, V1 (Administrator in Training) stated, I did not know that (R16) hit (R1) when I walked up on them yesterday morning. I knew he was irritated, and he started cussing at me, but V17 never told me R16 had slapped R1. I didn't know that there was a verbal altercation that afternoon either. (V17) should have verbally told us that the incident occurred, not put a note under the door. There was no note under the door. We have told them and told them to report everything to us, and that if they don't they will be fired. This is ridiculous. We didn't start any kind of investigation because we never knew he slapped her or had a verbal altercation with her. All we knew was he had hit (R17) that afternoon. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 5/4/23 at 9:30 a.m., R17 was sitting in his room watching television. He was completely alert and oriented. R17 had a scab on his left hand from what appeared to be a skin tear and his lower lip was swollen with a cut. R17 appears elderly and frail. R17 has a walker in front of him, but he said he is unable to ambulate more than a step or two, so he uses a wheelchair. R17 indicated he is currently on Hospice, because I'm just getting old and going downhill. R17 stated he's lived here about six months, but his family wants him to move because they are concerned this is not the safest place for him. R17 stated, I was in the dining room and he (R16) was sitting next to me. (R16) was trying to open his ice cream, but was having a hard time. He put his ice cream down and I picked it up to open it, before I could even react, he (R16) was standing up from his chair and punched me in the face. Somehow in the scuffle my hand got busted open and was bleeding, my lip was busted open and was bleeding. (R16) kept yelling that I called him a n****r, but I didn't. Someone separated us. (R16) moved so fast, I didn't even have time to push my wheelchair out and away from him. When R17 was questioned if he was afraid to live in this facility or if he was afraid of any of the residents, including (R16). R17 stated, I'm not going to be afraid. I know I can't defend myself very well, but I won't live like that. On 5/4/23 at 10:18 a.m., R12 stated he was a witness to the incident on Tuesday between (R17) and (R16). R12 stated, I was sitting at the table next to them. (R17) was trying to help the guy (R16) and he just stood up and started swinging. (R17) never had a chance. He's confined to a wheelchair, what could he possibly do to defend himself? I mean, the other guy can walk. He (R16) tried saying (R17) said racial slurs to him, but he never did. The guy (R16) got (R17) good. His lip was bleeding all over. I'm just over being in this place. I was supposed to just be here for therapy and then go home, but I'm not sure I can finish my last 30 days here. It's just chaos, all the time. On 5/4/23 at 10:40 a.m., R18 stated, I was out there when (R16) hit (R17). That poor old man (R17) is in the wheelchair and can't defend himself, and (R16) just hauled off and punched him (R17) in the face. I saw blood on (R17's) face. (R17) didn't do anything. (R16) gets irritated pretty easily especially with (R1). On 5/4/23 at 11:35 a.m., V1 confirmed that an investigation was not started immediately after the incidents on 5/2/23 between (R1) and (R16). Therefore, the facility did not implement anything to prevent R16 from further assaulting any other residents. The facility's Room Roster, dated 5/1/23, documents that 118 residents reside in the facility. 2. R1's Nurse's notes, dated 3/20/24 at 9:00 a.m., document, (R1) out on patio for smoke pass and spit in another resident's (R4) face. Continue 1:1's. R1's Nurse's notes, dated 3/24/23 at 6:00 p.m. document, (R1) spit on another resident (R15) while sitting on the couch. (R1) agitating resident previous to spitting on him by touching him when asked to stop. Facility Initial Report email, dated 4/11/23, documents, Resident to resident incident: Residents involved R4, R1. Alleged resident to resident physical altercation. V35's (Activity Assistant) written undated statement documents, I was on the patio when (R1) started calling (R4) names and then (R1) spit in (R4's) face. Then, (R4) got up and smacked (R1's) head on the wall. Then they stopped after I got in between them. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	V32's (Activity Assistant) written statement, dated 4/11/23, documents, (V35) and I were passing and lighting cigarettes (R1) and (R4) started to yell back and forth. (R1) then spit in (R4's) face. R4 then smashed the back of (R1's) head into the brick wall. CNAs (Certified Nursing Assistants) and nurses came out and had it handled. (R1) went in but then came out again. She was calling staff members, 'b**ch,' and spitting at them. R7's written but undated statement, documents, (R1) keeps spitting on people and (R4) pushed (R1) into the wall and spit back on (R1). Then they were separated. R2's written undated statement, documents, (R1) spit on (R4) twice and (R4) got up to defend herself and pushed (R1's) head against the wall. They were separated after that. R20's written undated statement documents, (R1) spit on (R4) and (R4) pushed her face and pushed her down. After that they were separated. R4's written undated statement, (R1) spit on me and so I pushed her head against the brick wall. Then we were separated. R5's written undated statement documents, We were out for smoke break and (R4) asked (R1) to not touch her when she sat next to (R4). (R1) then spit in (R4's) face then (R4) grabbed (R1) by the throat and smashed her head off the brick wall then I pulled (R4) off (R1) and the fight stopped. R19's written undated statement documents, I saw (R1) spit on (R4) and then (R4) punched her and beat her head against the brick wall. V4's (Resident Care Coordinator) written undated statement documents, (R1) ran out of the C wing door. (R1) upset because she got into an altercation with (R4). She was outside on patio and called (R4) a b**ch. (R4) stated say it one more time. (R1) did. (R4) struck her. (R1) struck back and they were separated. A facility 5 day Final Report, dated 4/16/23, documents, It was reported on 4/11/23 that while both residents (R1 & R4) were in the facility's courtyard during a scheduled smoke pass that (R1) allegedly called (R4) a derogatory name, (R4) then returned the verbal gesture. It was then reported that (R1) allegedly expectorated on (R4). Reports continued that (R4) then allegedly struck (R1) with her hand then (R1) allegedly struck (R4) in return. Both residents have been placed on list to be seen by Psych Nurse Practitioner for evaluation and recommendations for further treatment. On 5/3/23 at 2:35 p.m., V32 (Activity Assistant) was sitting outside of R13's room whom she was supervising as a 1:1. V32 stated, I was on the smoke patio the night that (R4) hit (R1's) head off of the wall. We were on smoke break. I don't know who (R1's) 1:1 was that day. The 1:1 tends to sit inside of the building watching her through the window. They are not always with her. I heard commotion and (R1) spit in (R4's) face. Then that's when (R4) smacked (R1's) head off of the wall. I ran inside to get help. I haven't ever been told what the rules are when it comes to supervising a 1:1 resident. I think you just have to visualize them. I work activities in the evening, but sometimes when I get here they tell me I have to do 1:1 with either (R13) or (R1). I'm not the person to ask what we are supposed to do in the case of a resident fight. I haven't gotten any training on this stuff. I just get handed the 1:1 sign off sheet. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 5/4/23 at 11:35 a.m., V1 stated, After the 4/11/23 incident, I talked to (R4) about controlling her anger. When the altercation starts staff should separate them immediately and get them calmed down. I don't know how (R1) ended up still getting hit even though she had a 1:1. I wasn't there to witness it. They should be interjecting and getting in between the residents. I've talked to (V31 Unit Aide) about stepping in when things are escalating. We have educated staff to de-escalate the situation. I don't think staff are afraid to intervene. (R1) is not instigating the other residents, it's the other residents that are having the behaviors towards (R1). There was no formal training done after this incident (4/11) just talking to the staff. R1's Behavior note, dated 4/13/23 at 9:19 p.m., documents, (R1) on patio calling people names threatening to spit on them. Residents came inside after smoke break. (R1) spit at (R2). (R2) told her to spit again. She spit again. (R2) attacked her. The residents were separated and they attacked each other again. They were separated and started spitting at each other in between staff. A facility 5 Day Final Report, no date, documents, It was reported that (R1) allegedly called (R2) a 'b**ch' which caused (R2) to return the verbal gesture. It was reported that (R1) then alleged spat in (R2's) face. (R2) allegedly hit (R1) in face and spat back on (R1). R2's Incident Investigation Interview form, dated 4/14/23, documents, (R2) stated that while near the nursing station (R1) spat on (R2). That is when (R2) hit (R1). R2's Nurse's Notes, no date, document, (R2) stated that (R1) was calling her names spitting at her and she pinned (R1) to the wall and hit her. R2's Behavior note, dated 4/13/23 at 9:29 p.m., documents, (R1) on patio calling people names threatening to spit on them. Residents came inside after smoke break. (R1) spit at (R2). (R2) told her to spit again. (R1) spit again. (R2) attacked her. The residents were separate and they attacked each other again. They were separated and started spitting at each other in between staff. On 5/4/23 at 10:35 a.m., R2 stated, (R1) had spit on me at least three different times, and I couldn't take it anymore. The last time she spit on me I punched her in the face twice. She had a 1:1 with her, but they don't do anything to interfere or stop anything. They might ask her to not spit and that's it. These little teenagers don't do anything. R1's Incident Investigation Interview, dated 4/25/23, documents, (R16) walked by and called me a f**king b**ch and a 'ho' and told me I needed to go home. Facility 5 Day Final Report, dated 4/28/23, documents, Original complaint: It was reported on 4/25/23 that while in the common areas (R16) allegedly called R1 a b**ch and told her she needed to go home. Residents will be offered 1:1 time with social services once a week for 3 weeks. R1's Incident note, dated 4/26/23 at 6:45 p.m., documents, This nurse was notified by staff member that this resident was exchanging curse words with a male resident (R15), this resident became increasingly agitated and spit on (R15) in his face. V33's (Unit Aide) written statement, no date, documents, (I) was walking with R1, she and R15 was exchanging words (cursing) with each other. R1 got mad and spit on R15 in his face and walked away to the nurses' station. (continued on next page)

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	146097	A. Building B. Wing	05/08/2023

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	R15's Incident Investigation Interview form, dated 5/1/23, documents, (R15) states (R1) got mad at him for not saying 'hi' they exchanged words and then she spit on him. A facility 5 day final report, dated 5/1/23, documents, It was reported on 4/26/23 that (R1) and (R15) allegedly exchanged curse words with one another. (R1) became upset and allegedly spit on (R15). (R1) still remains on 1:1 supervision. Residents will be offered 1:1 time with social services once a week for three weeks. A facility Five Day Final Report, dated 5/2/23, documents, It was reported on 4/27/23 that during an afternoon smoke pass (R4) had touched (R1). At that time (R1) was spitting everywhere and allegedly spit on (R4). (R4) states she just reacted and allegedly hit her. Residents will be offered 1:1 time with social services once a week for three weeks. R4's Incident Investigation Interview form, dated 4/27/23, documents, At 1:30 p.m. smoke pass out on patio, I was sitting in a chair (R1) touched me and I (said) don't touch me. She was spitting everywhere and then spit on me on my face. My reaction was to push her away but she was close and my arm and hand made contact with her. V34's (Activity Assistant) written statement, dated 4/27/23, documents, (R1) spit at (R4). Unit aides came between them. I continued lighting cigarettes. I turn around to yelling and (R4) hitting (R1). V17's (Unit Aide) written interview, dated 5/1/23, documents, Have you ever witnessed (R1) and (R4) be inappropriate towards one another? Yes smoke pass or in the TV room. Usually (R1) says hello and (R4) says, 'Don't talk to me.' R1's response is always, 'B**ch. On 5/2/23 at 10:50 a.m., R4 was alert lying in bed. R4 stated, (R1) spits at me and in my face all the time. No one does anything to stop her even her 1:1. Both times I hit (R1) I just got so fed up I couldn't take it anymore. R1's Care plan, dated 5/1/23, documents, (R1) has potential to be physically aggressive related to Bipolar and TBI with poor impulse control. The care plan also documents the following intervention: (R1) was called a 'b**ch ' and told to go home by another resident. Offered 1:1 time with social services once a week for three weeks. Still remains on 1:1 supervision. (R1's) care plan has no revision to include (R1's) behavior of spitting on other residents causing altercations. On 5/1/23 at 11:35 a.m., R13 stated, I never see the 1:1's for (R1) or (R14) and if I do they are on their phones not watching them. All you ever see is these little teenage 1:1's who are too busy texting their friends or taking pictures of themselves. They don't care about where their residents are at. On 5/2/23 at 10:00 a.m., R1 was sitting outside smoking. Her 1:1 staff member, V17 (Unit Aide) was watching her through the window from inside of the facility. V17 stated, I have never witnessed a physical altercation with (R1) until today. She gets verbally aggressive a lot with other residents. Today (R1) and (R16) got verbal with each other and (R1) started calling (R16) a b**ch then he slapped her a few times in the face. When she starts to get verbal with other residents, I try to remove her, but she's stubborn. I can't always get the other resident to leave either. When (R1) gets verbal, the other residents get mad and hit (R1). (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 5/2/23 at 11:20 a.m., V33 (Unit Aide) stated, (R1's) behaviors depend on who she is sitting with. If she's sitting with (R16) or (R15) it's trouble. At smoke time, (R1) likes to cut in line and that does not go over well with the others. If (R1) is mad she will hit and kick other residents. I try telling her we need to leave or go for a walk, go for a break, we can go sit in her room or go down the hall. I try giving her ice too. Most of the time she will not get up. So, I have to go get the nurse. The nurse doesn't really help a lot of times because they just do the same thing I already did, and it doesn't help. I may ask the other resident then to move, and sometimes that will help. (R16) will just keep arguing with her. (R16) gets in her face. The other day I had to get (V1 Administrator in Training) because (R16) was in her face. The incident (4/13/23) with (R2) started outside. They were arguing about something during smoke pass. I told (R1) to put her cigarette out so we could go inside to get away from it. Then, (R1) came in and (R1) spit on (R2) and (R2) hit (R1). The incident (4/26/23) with (R15) was (R1) got done eating dinner and sat next to (R15). (R15) said he didn't want her to sit there and asked her to move. I tried to get (R1) to move. (R1) wouldn't move so (R15) started to get rude and then (R1) got rude and kicked (R15). Basically we are just taught to try to redirect them, and if that doesn't work then get the nurse. Not much else is taught to us if we aren't able to redirect them we have to leave the residents alone to get the nurse. On 5/2/23 at 1:40 p.m., V13 (Social Services) stated, (R1) has been on 1:1 ever since I got here. (R1) spits on other residents quite a bit. I talk to her about being inappropriate, but (R1) doesn't remember it. (R1) doesn't remember long term. (R1) wouldn't remember spitting on people. Certain people (R1) is not supposed to be by like (R16) because they get each other riled up. I haven't been documenting the 1:1 sessions because I haven't been doing them. On 5/3/23 at 12:20 p.m., V17 stated, (R1) and (R16) had two incidents yesterday. The one where he slapped her across the face in the morning, and then in the afternoon they had a verbal altercation. Around 1:15 p.m., (R1) sat next to (R16). I asked (R1) to not sit there and we could sit somewhere else, and she refused to move. (R1) reached over and touched (R16's) hair, and (R16) said, Keep your f**king hands off of me. (R1) wouldn't move so I asked (R16) if he would move, and (R16) told me, [NAME] lady you aren't going to tell me what the f**k to do. On 5/3/23 at 12:00 p.m., V12 Registered Nurse stated, I don't know how other resident's are able to hit (R1) if she has a 1:1 with her at all times. I question it all the time. I know (R1) likes to instigate and spit on residents and get verbal. She picks at other residents all the time. On 5/3/23 at 1:40 p.m., V36 CNA (Certified Nursing Assistant) stated, If you are 1:1 with (R1) she just has to be within visual distance. On 5/3/23 at 1:05 p.m., R1 was sitting on the couch in the TV room. R1's 1:1 staff member, V37 (CNA), was sitting approximately 15 feet away from R1. On 5/4/23 at 11:35 a.m., V1 stated, The staff are all educated on redirecting the residents and trying to deescalate the situation. When V1 was asked how the perpetrators are able to hit R1 even with 1:1 staff present, V1 stated, Are you expecting this little teenage boy to jump in between these residents who are fighting? Have you seen these residents and how big they are? I educate these teenagers but they don't process this information well. V1 also stated, The 1:1 staff member should be within arms' length of the resident they are supervising. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 5/4/23 at 12:05 p.m., V9 (Regional Clinical Director) stated, What are you wanting us to do? Do you want the staff members to push the resident out of the way so there is no physical contact. The staff member pushes the resident, and the resident gets hurt then you are after us because that staff member wasn't trained properly. Regardless of what we do is wrong. We are doing our best here with this population that we have in this facility. I've gotten IJs (Immediate Jeopardy's) for this. On 5/4/23 at 12:15 p.m., V4 (Resident Care Coordinator) stated, Can you tell us what we are supposed to be doing here if we aren't taking care of these residents like we are supposed to? What do you want us to do? We are doing everything we can with (R1). We have call's out to other facility's to see if they could take better care of her, but we haven't heard back from any of them. On 5/8/23 at 2:15 p.m., V31 was sitting in front of fireplace while R1 was sitting on the couch in the TV room. V31 stated he got training on Thursday and they went over that the 1:1's needed to watch their residents better. V31 also stated, When it comes to watching (R1) I just need to have visual contact of her (R1 was approximately 20 feet away from V31 sitting on a couch). R16 walked up in front of R1 bent over and grabbed her thigh and was laughing. R16's 1:1 staff member V28 (CNA) was walking with R16 and did not address the interaction. V31 stated, We are supposed to keep (R1) and (R16) separated they need to be at least six feet apart. The Immediate Jeopardy started on 4/25/23 when R16 called R1 a b**ch and threatened to cut R1. On 5/4/23 at 1:25 p.m., V1 (Administrator in Training), V2 (Assistant Administrator in Training), V3 (Director of Nursing), V4 (Resident Care Coordinator) and V5 (Corporate Staff) were notified of the Immediate Jeopardy and Substandard Quality of Care. On 5/8/23, the surveyor confirmed through observation, interview, and record review that the facility took the following actions to remove the Immediate Jeopardy. 1. V1 and V2 were educated on Abuse Identification and Prevention by V9 (Regional Clinical Director) on 5/4/2023. 2. V1 and V2 initiated staff education on Abuse Identification and Prevention on 5/4/2023. 3. V2 educated by V9 on what to do in the situation of an altercation to protect the residents on 5/4/2023. 4. V2 initiated education to staff on what to do in the situation of an altercation to protect the residents on 5/4/2023. 5. V2 educated by V9 on how to effectively provide 1:1 supervision on 5/4/2023. 6. V2 initiated education to staff on how to effectively provide 1:1 supervision on 5/4/2023 7. Residents with known history of altercations to be monitored through internal QAA process through behavior monitoring program and reviewed by Quality Assurance Team during weekly behavior QAA, Quarterly QAA and more frequently as needed. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	8. Quality Assurance Team to be review implementation and effectiveness of interventions put into place to prevent further abuse through daily QA meeting 9. Facility newly hired PRSC to initiate Social Service programming with residents to include conflict resolution techniques and impulse control. 10. Quality Assurance Team to conduct random rounds/interviews ensure staff is aware of what to do in a situation of an altercation. This will be done weekly for four weeks by V2. 11. V1 or designee to ensure any staff member who is performing 1:1 duties will be educated on how to effectively provide 1:1 supervision. 12. In-servicing training by V2 on Abuse Prevention Policy with all staff will continue monthly for the next 3 months, then quarterly times three by V2 or V3 (Director of Nursing). 13. All new employees to be in-serviced on Abuse Prevention Policy upon hire during orientation process prior to working with residents.

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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. 33960 Based on observation, interview, and record review, the facility failed to ensure the administrator was notified immediately of an allegation of verbal and physical abuse, and an allegation of abuse was reported timely to the State Agency for four of 20 residents (R1, R11, R12, R16) reviewed for abuse in the sample of 20. These failures had the potential to affect all 118 residents residing in the facility. Findings Include: The facility's Abuse Prevention Program policy, dated 11/28/16, documents, 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 administrator. The policy also documents, The administrator or designee is then responsible for forwarding a final written report of the results of the investigation and of any corrective action taken to the State Agency within five working days of the reported incident. 1. On 5/2/23 at 10:00 a.m., R1 was sitting outside smoking. R1's 1:1 staff member, V17 (unit aide), was watching her through the window from inside of the facility. V17 stated, I have never witnessed a physical altercation with (R1) until today. She gets verbally aggressive a lot with other residents. Today her and (R16) got verbal with each other and she started calling him a b**ch then he slapped her a few times in the face. On 5/3/23 at 12:20 p.m., V17 stated, (R1) and (R16) had two incidents yesterday. The one where he slapped her across the face in the morning, and then in the afternoon they had a verbal altercation. Right after he hit her, (V1 Administrator in Training) came up on the commotion. (R16) went off on (V1). He started yelling and cussing at her. I didn't notify anyone about what happened because (V1) told me she had it all taken care of. Around 1:15 p.m., (R1) sat next to (R16). I asked her to not sit there and we could sit somewhere else, and she refused to move. She reached over and touched (R16's) hair, and he said, 'Keep your f**king hands off of me.' (R1) wouldn't move so I asked (R16) if he would move, and he told me, 'White lady you aren't going to tell me what the f**k to do.' The office door was closed when I left, so I put a note under the door to let (V2 Assistant Administrator in Training) know what happened with that incident. On 5/3/23 at 2pm, V1 (Administrator in Training) stated, I did not know that (R16) hit (R1) when I walked up on them yesterday morning. I knew he was irritated, and he started cussing at me, but (V17) never told me that he had slapped (R1). I didn't know that there was a verbal altercation that afternoon either. (V17) should have verbally told us that the incident occurred, not put a note under the door. There was no note under the door. We have told them and told them to report everything to us, and that if they don't they will be fired. This is ridiculous. On 5/3/23 at 12:10 a.m. V22 Registered Nurse stated that R16 is able to independently ambulate throughout the entire facility. The facility's Room Roster, dated 5/1/23, documents that 118 residents reside in the facility. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	32061 2. The (undated) Facility Incident Report documents, It was reported that (R12) allegedly walked up to (R11) and hit him in the back. Residents separated immediately for safety precautions. Statements obtained by various employees and residents that may have witnessed alleged incident. Statements obtained by both involved residents to gather further information. (Physician), Power Of Attorney, (Local) Police Department contacted and informed of alleged incident. The (Local) Police Report for the incident between (R11) and (R12) documents, On 4/1/23 I received a call from the (facility) Charge Nurse (V12/Licensed Practical Nurse). (V12/LPN) stated she wanted to report an assault that occurred at about 12:15 PM between two residents (R11) and (R12). V12/LPN stated that she did not see the assault and was informed only. V12/LPN stated that (R11) was walking in the hallway and was struck in the lower back by (R12). (V12/LPN) stated that (R12) punched (R11) in his lower back with a closed fist. (V12/LPN) stated both residents were separated and returned back to their rooms without further incident. No arrests associated with this incident. On 5/2/23 at 1:08 P.M., (V11/Physical Therapy Assistant) stated on (4/1/23) she and (R12) were seated in the foyer doing seated exercises and (R11) walked past (R12), stopped and mumbled something and (R12) reached out and hit (R11) in the back, one time. (V11/PTA) further states both residents were immediately separated and returned to their rooms. (V11/PTA) states she immediately reported the incident to the charge nurse. On 5/2/23 at 1:58 P.M., V2/Assistant Administrator In Training verified the facility did not notify the State Agency of the final investigation of the incident from 4/1/23.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33960 Based on observation, interview, and record review the facility failed to investigate timely an allegation of potential sexual abuse and failed to ensure an alleged victim was protected from further abuse during the investigation for four of 20 residents (R1, R7, R8, R16) reviewed for abuse, in a sample of 20. This had the potential to affect all 118 residents residing in the facility. FINDINGS INCLUDE: The facility policy, Abuse Prevention Program, dated (revised) 11/28/2016 directs staff, This facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property and exploitation. This will be done by immediately protecting residents involved in identified reports of possible abuse, implementing systems to investigate all reports of possible abuse. 1. On 5/2/23 at 10:00 a.m., R1 was sitting outside smoking. R1's 1:1 staff member, V17 (unit aide), was watching her through the window from inside of the facility. V17 stated, I have never witnessed a physical altercation with (R1) until today. (R1) gets verbally aggressive a lot with other residents. Today (R1) and (R16) got verbal with each other and (R1) started calling (R16) a b**ch then he slapped her a few times in the face. On 5/3/23 at 12:20 p.m., V17 stated, (R1) and (R16) had two incidents yesterday. The one where (R16) slapped (R1) across the face in the morning, and then in the afternoon they had a verbal altercation. Right after (R16) hit (R1), (V1 Administrator in Training) came up on the commotion. (R16) went off on (V1). He started yelling and cussing at her. I didn't notify anyone about what happened because (V1) told me she had it all taken care of. Around 1:15 p.m., (R1) sat next to (R16). I asked her to not sit there and we could sit somewhere else, and she refused to move. She reached over and touched (R16's) hair, and he said, 'Keep your f**king hands off of me.' (R1) wouldn't move so I asked (R16) if he would move, and he told me, 'White lady you aren't going to tell me what the f**k to do. On 5/3/23 at 12:10 a.m. V22 Registered Nurse stated that R16 is able to independently ambulate throughout the entire facility. On 5/3/23 at 2pm, V1 (Administrator in Training) confirmed that she was notified of R1 and R16's two incidents by V17. On 5/4/23 at 11:35 a.m., V1 confirmed that an investigation was not started immediately after the incidents on 5/2/23 between R1 and R16. The facility's Room Roster, dated 5/1/23, documents that 118 residents reside in the facility. 32061 2. R7's (May 2023) Physician Order Sheet documents that R7 was admitted to the facility on [DATE] with the following diagnoses: Schizoaffective Disorder, Bipolar Type and Moderate Intellectual Disabilities and Depression. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility State Agency Form, dated 4/12/2023 documents, Resident to resident sexual allegation. Residents separated immediately. Investigation initiated. 5 day to follow. On 5/1/2023 at 12:45 P.M., R7 verified (R8) was his roommate for awhile. When questioned if episodes of (R8) placing his mouth on (R7's) genitals happened often, R7 verified, frequently. When asked if he had reported this to facility Management at any time, (R7) verified, Once. (R7) then returned to his noon meal and would not answer further questions. On 5/1/2023 at 1:26 P.M., V13/Social Services stated, (On) April 11th (2023) (the facility) held a resident council meeting, afterwards (R7) came to me and said he wanted to talk to me about his roommate (R8). (R7) told me (R8) would pull the room curtain, so that no one could see him if they opened the door, and would place his mouth on (R7's) genitals. (R7) told me it had been happening for a while and it had happened again last night (4/10/23). (R7) said he wanted it to stop. I went straight to (V1/Administrator in training) after (R7) told me about it and made her aware. I don't know if (V1/Administrator in training) called the Police. I interviewed (R8) on 4/12/23 and he told me the allegation was untruthful. On 5/1/2023 at 1:01 P.M., R8 stated that he and (R7) were roommates for about a year and recently staff asked him to move without giving him a reason why. States he and (R7) enjoyed watching television together and he liked helping (R7) with his wheelchair. When asked if he and (R7) had a sexual relationship, R8 stated no, they were just friends. On 5/1/2023 at 1:55 P.M., V1/Administrator in training stated V3/Director of Nurses told her about the incident on April 12th (2023) and she started an investigation then. She stated she did notify the Police. On 5/2/2023 at 12:08 P.M.,V3/Director Of Nurses stated she became aware of the situation of R7 accusing R8 of potential sexual assault on April 13th (2023). V3/DON further states they (V3 and V13/Social Services) went to V1/Administrator in training immediately and reported the incident. V3 stated they moved (R8) (out of the same room as R7) on that day, too. R8's (facility) Census Report documents, 4/12/23 C-Wing room [ROOM NUMBER]-1 and on 4/13/2023 C-Wing room [ROOM NUMBER]-1. On 5/2/2023 at 1:15 P.M., V13/Social Services stated, I became aware of R7's concerns (of potential sexual abuse against R8) on 4/11/23 right after the Resident Council Meeting. R7 came up to me and said he needed to talk to me about (R8). Notes provided by the facility document that the monthly Resident Council Meeting was held on 4/11/23, with R7 in attendance.

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	05/08/2023

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 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. 33960 Based on observation, interview, and record review, the facility failed to provide sufficient social services staff to meet the behavioral needs of the residents. This has the potential to affect all 118 residents residing in the facility. Findings include: The Facility Assessment, dated 4/20/21, documents, The facility provides services to patients having a variety of mental health illnesses as well as medical needs. Resident support/care needs: Mental health and behavior: Manage the medical conditions and medication related issues causing psychiatric symptoms and behaviors, 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, other psychiatric diagnoses, intellectual or developmental disabilities. The Assessment also documents, We are dedicated to assisting the elderly population in maintaining the highest possible quality of life. We believe that all aspects of a person must be considered physical, mental, spiritual and social, when assessing and providing care for all individuals. Facility 5 Day Final Report, dated 4/28/23, documents, Original complaint: It was reported on 4/25/23 that while in the common areas R16 allegedly called R1 a b**ch and told her she needed to go home. Residents will be offered 1:1 time with social services once a week for 3 weeks. A facility 5 day final report, dated 5/1/23, documents, It was reported on 4/26/23 that R1 and R15 allegedly exchanged curse words with one another. R1 became upset and allegedly spit on R15. R1 still remains on 1:1 supervision. Residents will be offered 1:1 time with social services once a week for three weeks. R1's Care plan, dated 5/1/23, documents, R1 has potential to be physically aggressive related to Bipolar and TBI with poor impulse control. The care plan also documents the following intervention: R1 was called a 'b**ch ' and told to go home by another resident. Offered 1:1 time with social services once a week for three weeks. Still remains on 1:1 supervision. A facility Five Day Final Report, dated 5/2/23, documents, It was reported on 4/27/23 that during an afternoon smoke pass R4 had touched R1. At that time R1 was spitting everywhere and allegedly spit on R4. R4 states she just reacted and allegedly hit her. Residents will be offered 1:1 time with social services once a week for three weeks. On 5/2/23 at 1:30 p.m., R17 was observed propelling himself towards V1's (Administrator in Training) Office. R17 was bleeding from his mouth and his right hand was actively bleeding. At that time R17 stated, He (R16) punched me in the mouth. All I was doing was trying to help him open his ice cream. (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	05/08/2023

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 5/2/23 at 1:40 p.m. V13 (Social Services) stated, A lot of the incidents occur in the evening when I'm not here. I haven't been documenting the 1:1 sessions because I haven't been doing them. With it just being me I can't do everything that we need social service wise. We aren't able to have group sessions. I used to be able to do it when there was three social services (staff) and the residents loved it. V13 confirmed that there was no documentation of 1:1 group sessions occurring. On 5/2/23 at 2:47 p.m., V18 (CNA-Certified Nursing Assistant) stated, (V13) is only one person and she can't provide all of the social services that these people need. On 5/3/23 at 11:50 a.m., V21 CNA stated, When we had more Social Service staff the behaviors weren't as bad. With only (V13) there is too much going on that she isn't able to do counseling or group sessions. On 5/4/23 at 11:35 a.m., V1 (Administrator in Training) stated, No we don't have social service programming going on. The social service program is broke down right now we don't have the staff. (V13 Social Service) is doing one on one meetings with some of the residents that are involved with these incidents. The intervention was the 1:1 session. (V13) was informed that she was supposed to begin them, and she told us she was. What am I supposed to do when I ask (V13 Social Services) if she is doing them, but then I find out she isn't doing them. The 1:1 sessions should be going on. The facility's Room Roster, dated 5/1/23, documents that 118 residents reside in the facility.