STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145319	A. Building B. Wing	08/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arc at El Paso	555 East Clay El Paso, IL 61738

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to prevent staff to resident verbal abuse for two of three residents (R2 and R3) reviewed for abuse in a sample of three. Findings include:The facility's 24-hour Abuse Investigation Report, dated 7/16/25, documents V1, Administrator, was informed V4 (Certified Nursing Assistant), alleged cussing and yelling at a resident (R3) during care. V4 was suspended immediately pending investigation.V10's, Certified Nursing Assistant, signed statement, dated 7/17/25, documents R3 put on her call light. V4 said, Why did you have me pull you the F K up in the bed? This form also documents V4 is rough towards residents.On 8/19/25 at 3:00pm, V10, Certified Nursing Assistant, stated V4 answered R3's call light and wanted to be pulled up. V10 stated he heard V4 say Why the F k do you want me to pull you up, when all you do is slide right back down? V4 stated he used several other curse words while he was in the room. V10 stated he told the nurse right away. On 8/19/25 at 12:30pm, V1, Administrator verified he did not consider V4 cussing at R3 verbal abuse. V1 also stated the second allegation was not founded because V4 quit before the investigation could be completed. V1 stated corporate makes the final decisions concerning the allegations of abuse. V11's Certified Nursing Assistant, signed statement dated 7/17/25, documents V4 can be kind of rude to residents and use curse words and yell at them.R2's statement, undated, documents the CNA said, I need to get up. I told him I did not want to get up. It seemed to make him mad. He pushed down on my hands and said we got to go, hurry up.On 8/18/25 at 10:00am, R2 stated V4, Certified Nursing Assistant, was attempting to get her out of bed one morning. R2 stated she did not want to get up, so she told him no. R2 stated V4 came in and held her arms down to make her get dressed. R2 stated she continued to refuse. R2 verified V4 was rough while attempting to get her dressed. R2 stated she told the next shift what happened.On 8/19/25 at 11:00am, V4 stated he was suspended twice for allegations of abuse. V4 stated the first time was because of an allegation of him cussing at a resident. V4 stated instead of a three-day suspension, it was nine days, because he had to retake the abuse, customer service training. V4 stated the second time was because of being rough with a resident. V4 stated he stayed over to help the day shift and was told everyone had to get up for breakfast. V4 stated R2 kept refusing, so then he began to persuade her to get up. V4 stated he was just tired of all the allegations and quit.The facility's Final Abuse Investigation, dated 7/30/25, documents R2 stated, The tall male CNA, (V4) with tattoos, was rough with her while trying to get her out of bed for the day. R2 stated, I kept telling him I don't want to get out of bed, and it seemed to make him mad. This form documents V4 was suspended immediately pending an investigation, but V4 voluntarily terminated his position effective 7/26/25.The facility's Abuse Prevention and Reporting policy, revised 9/2024, documents the facility prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. This form documents verbal abuse may be considered to be a type of abuse. Verbal abuse includes the use of oral, written, or gestured communication, or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability.