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	07/01/2026

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow its abuse prevention policy for three of four residents (R2, R3, and R4) with abuse-related concerns. Findings include:1. R2 had an allegation that R2 had been called a racial slur. The facility knew about the allegation and moved R2 to a different room after administration was made aware. The facility did not provide documentation showing the allegation was reported to the State Agency, investigated, concluded, or followed up on. On [DATE] at 12:12 PM, V3/LPN stated concerns regarding R2's previous roommate (now deceased) calling R2 a racial slur were brought to management's attention by V3. V3 stated, I advocated to have R2 moved to a different room because he was being called racial slurs by his roommate. I notified V1, Administrator, of the incident and that's why they moved R2 to a different room. I never heard anything else about it. Management does not follow up on concerns at the facility. This is an ongoing issue with the administration at the facility.R1's electronic health record contained no documentation of the room move at the time of the incident other than in the Census line and no documentation the facility reported the allegation involving R2 being called a racial slur to the State Agency. Review of facility documentation did not show the facility completed an abuse investigation related to R2's allegation. The facility did not provide documentation showing it protected R2 from further possible abuse, interviewed R2, interviewed the alleged resident, interviewed witnesses, reviewed records, checked how the incident affected R2, documented findings, reached a final decision, or took action to prevent it from happening again.On [DATE] at 12:40 PM, V1, Administrator, and V2, Director of Nursing, confirmed they were aware of the allegation that R2 was called a racial slur and that R2 was moved to a different room. V1 initially stated he was not aware of the allegation; however, after V2 confirmed awareness of the concern and that it had been discussed with Administration, V1 confirmed the facility was aware of the situation. V1 and V2 confirmed the facility did not complete an abuse investigation and did not report the allegation to the State Agency.On [DATE] at 12:43 PM, V11, Regional Director of Operations, stated the allegation involving R2 being called a racial slur should have been reported. V11 stated the facility should have done something to prevent the abuse from happening again. V11 stated, This is very concerning for me, and stated she needed to decide what to do about the situation.V1, Administrator's initial statement that he was not aware of the allegation was inconsistent with the later confirmation by V1 and V2 that the facility knew about the allegation and moved R2. The facility's documentation did not support that the facility followed its abuse prevention policy after learning of the allegation. The facility did not provide documentation showing the allegation was reported, investigated, concluded, or followed up on.The facility failed to follow its abuse prevention policy for R2 when it failed to treat the racial slur allegation as possible verbal abuse or mistreatment, failed to report the allegation to the State Agency, failed to complete and document an investigation, failed to document protection measures, failed to document follow-up with R2, failed to document a final decision, and failed to document what was done to prevent it from happening again.2. R3 had concerns related to staff treatment, refusal or delay of help, dignity, and possible mistreatment. R3 reported staff conduct/mistreatment to V1, Administrator, that should have been reviewed by the facility as possible mistreatment, neglect, retaliation, or degrading treatment. (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

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	07/01/2026

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 11:45 AM, V7, CNA, stated she reported allegations of mistreatment/abuse to V1, Administrator, related to R3 and V10, CNA, multiple times. V7 stated, He just sweeps everything under the rug. V7 stated R3 told V7 that V10 told R3 she was lazy because she wanted a lid taken off of her cup. On [DATE] at 1:03 PM, R3 stated V10, CNA, was intimidating, demanding, and argued with R3. R3 stated R3 told V1, Administrator, and nothing was done. R3 stated V10 pulled a chair up to R3's bed after arguing, waited, and did not come in when R3 needed help. R3 stated V10, called R3 lazy and V10 was not a nice person to her on multiple occasions. R3 stated V10 made her feel bad about herself and did not like to help her even though she needed assistance. On [DATE] at 1:10 PM, V1, Administrator, stated there was no investigation related to R3's concern, but V1 was aware of the situation and spoke with V10, CNA, about the incident.On [DATE] at 1:44 PM, V10, CNA, stated R3 asked her to remove a lid and V10 refused to do so. V10 stated, I told her she could do it herself. We (R3 and V10) always had issues and would get into arguments when bathing R3 too. V10 stated she told R3, Your hands or arms aren't broke, and stated R3 got upset. Administration talked to (V10) about the situation. V10 stated she did not want to do anything for R3 because she felt like it's a race thing and stated R3 had a problem with her no matter what V10 did.Review of the facility's abuse and reportable documentation did not show the facility reviewed R3's concern as possible mistreatment, neglect, dignity concern, retaliation, or abuse-related concern. The facility did not provide documentation showing it determined whether the concern had to be reported, protected R3 from further possible mistreatment, interviewed R3 when the concern was reported, interviewed V10 when the concern was reported, interviewed witnesses, reviewed records, followed up with R3 about how the concern affected R3, documented findings, or reached a final decision.The facility failed to follow its abuse prevention policy for R3 when it treated the concern as a general staff and resident conflict or task-assistance issue. The facility failed to review R3's report of arguing, refusal or delay of help, and feeling bad about herself as possible mistreatment or degrading treatment. The facility failed to determine whether the concern required reporting, failed to process the concern through the abuse prevention policy, failed to investigate the concern, and failed to document a decision or follow-up action.3. R4 had an allegation involving degrading staff conduct during wound care. The allegation involved staff conduct that made R4 feel embarrassed, fearful, and degraded during care.On [DATE] at 10:00 AM, V8, Registered Nurse, stated R4 reported a concern regarding V14/LPN to V8. V8 stated recently within the last couple weeks, staff came and got V8 because R4's bandages were wet and R4 was upset when V8 entered the room. V8 stated the concern involved V14/LPN saying the bandages were gross and she did not want to catch anything from R4's draining wounds. V8 stated this was a dignity concern and it was reported to V1, Administrator, and as neglectful and abusive. V8 stated V8 also reported the concern to V2/Director of Nursing. V8 stated R4 wanted to discharge and did not want the staff member to care for him anymore. On [DATE] at 12:35 PM, R4 stated V14/LPN came into R4's room to complete wound care. R4 stated V14 had a disgusted look on her face, sighed, and asked if R4's wounds were contagious. R4 stated the interaction made R4 feel angry, degraded, and awful about himself. R4 stated R4 was fearful and wondered what the nurse said to other residents who couldn't speak for themselves or stand up for themselves.On [DATE] at 2:40 PM, V1, Administrator, stated he did not have an abuse investigation related to the incident between R4 and V14/LPN. Review of facility abuse and reportable documentation did not show the facility completed an investigation related to R4's allegation. The facility did not provide documentation showing the allegation was reported to the State Agency, reviewed as possible abuse, neglect, or mistreatment, or reviewed for R4's dignity, emotional impact, protection, or follow-up.The facility had knowledge of the concern before the surveyor interview with R4 because V8 stated V8 reported the concern to V1, Administrator, and another facility manager. The facility did not provide documentation showing it followed its abuse prevention policy after receiving the report. The facility did not provide documentation showing it determined whether the allegation had to be reported, protected R4 from further possible mistreatment, interviewed R4, interviewed the alleged staff member, interviewed (continued on next page)

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	07/01/2026

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R4's wife as a witness, reviewed wound-care documentation, followed up with R4 about how the concern affected R4, documented findings, reached a final decision, or took corrective action.The facility failed to follow its abuse prevention policy for R4 when it failed to recognize and process the allegation of degrading treatment during wound care as possible abuse, neglect, mistreatment, or dignity-related harm. The facility also failed to act on V8's report that the concern was neglectful and abusive, failed to determine whether the concern required reporting to the State Agency, failed to complete an investigation, failed to document findings or a decision, and failed to complete resident follow-up or action to prevent the same concern from happening again.On [DATE] at 1:10 PM, V1, Administrator, stated all abuse allegations were expected to be investigated fully, documented, and reported accordingly. V1 stated R2, R3, and R4's allegations of abuse were not investigation, documented, or reported and should have been.On [DATE] at 12:43 PM, V11, Regional Director of Operations, stated all abuse/neglect allegations should be investigated and reported. V11 stated the concerns about multiple allegations of abuse not being investigated, reported, or followed up on are very concerning. V11 stated she needed to decide how to handle the situation after being made aware due to the seriousness of the concerns. The facility policy titled, Abuse Prevention and Reporting - Illinois, revised 03/2026, documented the facility prohibited abuse, neglect, exploitation, mistreatment, and misappropriation of resident property. The policy documented any suspected abuse, neglect, exploitation, mistreatment, injuries of unknown source, or misappropriation of resident property was to be immediately reported to the Administrator/designee. The policy documented residents were to be protected from further possible abuse. The policy documented the facility was to complete a prompt and thorough investigation, including review of the allegation, identification of the alleged staff member, resident interviews, witness interviews, record review, documentation of findings, and a final decision. The policy documented investigation records were to be maintained and abuse-related concerns were to be reviewed for patterns, follow-up, and corrective action.