

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145319	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/28/2026
NAME OF PROVIDER OR SUPPLIER Arc at El Paso		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0689 Level of Harm - 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** Based on observation, interview and record review the facility failed to serve hot foods in a sturdy bowl, this failure caused R8 to spill hot chili on her chest causing a burn with blistering that required treatment for one resident (R8) reviewed for a burn injury in a total sample of thirty eight. Findings include: R8's Medical Record documents she was admitted to the facility on Hospice services on 12/10/2024 with diagnosis to include but not limited to Congestive Heart Failure, Atrial Fibrillation and Dementia. R8's Medical Record documents she is cognitively impaired and has short term memory problems. Throughout the survey R8 did not recall the incident on 3/24/26 with chili. The facility's Incident dated 3/24/26 documents V19 (Registered Nurse) was called to R8's room by V15 (Certified Nurse Aide) during lunch time because R8 had yelled out and was found with chili down the front of her chest. R8's Skin-Other Skin Condition assessment dated [DATE] documents R8 had a new skin concern: burn. The Skin-Other Skin Condition assessment documents area to right upper chest 15 cm (centimeters) by 9 cm red warm redness with mild skin sloughing to top layer. R8's Physician Order Sheet Dated March 2026 documents a new order from V10 (R8's doctor) for Silvadene cream to burn twice daily. On 5/27/26 V20 (R8's Family Member) stated R8 prefers to eat in bed, but V20 thinks she needs more supervision while eating. R8 stated, If someone had been in the room helping her with her lunch or making sure she could reach everything she would not have gotten burned. On 5/27/26 V15 (Certified Nurse Aide), V21 (Certified Nurse Aide) and V22 (Certified Nurse Aide) all confirmed they were the staff members who passed the room trays to residents on 3/24/26. All three V15 (CAN), V21 (CNA) and V22 (CNA) stated they do not remember who took R8's tray to her on that day. All denied any concerns with lunch that day prior to R8 receiving a burn from the chili. On 5/27/26 V15 (CNA) stated she heard R8 yell, Mom, I hurt! and then V15 could hear R8's roommate yelling that R8 had spilled something. V15 (CNA) stated she immediately put a cool cloth on R8's chest because it was red, hot and very painful to R8. V15 (CNA) stated V19 (Registered Nurse) applied Silvadene cream to R8's chest. V15 stated, The area was pretty big, long and wide. R8's IDT (Interdisciplinary Team) Meeting note dated 3/25/26 documents, It was determined the incident (burn) was caused by her chili being served in a Styrofoam bowl. R8's IDT note does not include why a Styrofoam bowl was used instead of normal dinner ware. R8's Nurse's Note dated 3/24/26 at 12:15 PM documents, This writer went to kitchen to have the temperature of the chili redone. The temp of the chili at this time was 180 degrees. The Facility's Food Temperature Logs dated 3/24/26 documents Protein Final Cooked Temperature 190 degrees Fahrenheit. Protein Holding Temperature 187 degrees Fahrenheit. The Facility's Food Temperature Logs dated 3/24/26 document a key at the bottom Final Cooking Temperature Reference Casserole/Soup 165 degrees Fahrenheit. On 5/28/26 V8 (Cook) stated she did not know if 180 degrees Fahrenheit would be considered a safe temperature to serve a soup/casserole at per the facility's own printed key at the bottom of the Food Temperature Logs. V8 (Cook) could not provide temperature checks of meal trays that were sent to resident rooms at any point. V8 (Cook) did not know why R8 was served hot chili in Styrofoam instead of regular dinnerware. On 5/27/26 V1 (Administrator) confirmed the IDT notes, We think that she attempted to (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 145319
		If continuation sheet Page 1 of 11

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F 0689 Level of Harm - Actual harm Residents Affected - Few	pick up the bowl full of hot chili and the bowl failed and the hot chili hit her upper right chest. The new intervention is to always serve hot food in regular dinnerware. R8's Medical Record does not contain any information regarding education of R8 and/or V20 (R8's Health Care Power of Attorney) regarding any risks of eating unsupervised in her room. R8's Medical Record did not contain any safety risk assessment to determine what risks R8 would have to eat unsupervised. The Facility's Monitoring Food Temperatures for Meal Services policy dated 5/2026 documents If the serving/holding temperature of a hot food item is not at 135 degrees Fahrenheit or higher when checked prior to meal service the item will be reheated to at least 165 degrees Fahrenheit for a minimum of 15 seconds. Meals that are served on room trays may be periodically checked at the point of service for palatable food temperatures. Food temperatures of hot foods on room trays at the point of service are preferred to be at 120 degrees Fahrenheit or greater to promote palatability for the resident.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to prepare and serve food under sanitary conditions by not cleaning a debris/grime covered exhaust vent located above kitchen food preparation area. This failure has the potential to effect all 55 residents residing in the facility. Centers for Medicare and Medicaid Services [CMS] Form 671 [Long-term Care Facility Application for Medicare and Medicaid], dated 5/26/26, signed by V1/Administrator, document 55 residents reside in the facility. On 5/27/26, at 11:30 a.m., the exhaust vent, located above the kitchen's food preparation area, was covered with debris/grime. On 5/27/26, at 11:30 a.m., V7/Regional Dietary Manager confirmed the exhaust vent, above the food preparation area, should be cleaned. Facility Policy, entitled, On Tray Dietary Policies and Procedures Ceiling, Vents, document: Purpose: To ensure food safety. 1. Schedule with maintenance to complete the following. Remove all the parts of the vents that are removable (keep all the parts together) and wash, rinse, and sanitize in a proper location. 2. Wipe all the surfaces using a detergent solution and rinse. You may use degreaser to loosen the dirt. 3. Sanitize and allow to air dry. You may use degreaser to loosen the dirt. 4. Replace the removable parts of the vents. Wash and sanitize cleaning equipment and return to the proper storage area.		

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to ensure the lids of trash dumpsters, located outside, are closed/secure to prohibit pests/animals from gaining access to discarded food/trash. This failure has the potential to effect all 55 residents residing in the facility. Centers for Medicare and Medicaid Services [CMS] Form 671 [Long-term Care Facility Application for Medicare and Medicaid], dated 5/26/26, signed by V1/Administrator, document 55 residents reside in the facility. On 5/26/26, at 9:30 a.m., during the Initial kitchen tour, the two outside trash dumpsters were not secured as lids, on both were open. On 5/26/26, at 9:30 a.m., V8/Cook confirmed the trash dumpsters should have the lids closed. The facility's Pest Control Policy, effective 1/2026, document: Put garbage in sealed plastic bags before placing them in a covered, rodent-proof dumpster.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observations, interviews, and record review, the facility failed to implement an infection prevention and control system to identify, report, and manage infections and symptoms associated with communicable illnesses among residents; and failed to ensure proper disinfectant monitoring practices, including the use of testing protocols to verify acceptable disinfectant ranges and documentation of testing results for Legionella. These failures have the potential to affect all 55 residents who reside in the facility. Findings Include: On 5/27/2026 at 12:10 PM, V2 (Director of Nursing) confirmed she has no log that track infections or symptoms residents exhibit daily to track communicable infections and diseases. On 5/27/2026 at 12:30 PM, V13 (Maintenance Director) stated the Water Management Program Committee Protocol items listed to be completed are not completed. V13 stated there is no chlorine test that the facility or water department performs on a weekly or monthly basis to test the disinfectant in the water. The shower heads and aerators are not disinfected every six months and the ice machine is handled by the company that owns the machine and he does not have access to their cleaning schedule. The facility's Infection Prevention and Control Program policy dated 12/2025 documents, Purpose: to comply with a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement. Guidelines: 6. The program proves for the recording for each suspected infection and surveillance activities as they relate to the individual resident infections. A log is maintained of suspected and actual infections on a day-to-day basis. McGeer's Criteria is used to determine if criteria for an infection is met. The facility's Water Management Program for Prevention of Legionella Growth dated 02/2026 documents, Purpose: to reduce Legionella in the facility water systems to prevent cases and outbreaks of Legionellosis. Development of a Water Management Program: Implementing a water management program to reduce the buildings risk for growing and spreading Legionella. The elements of the Water Management Program should be reviewed annually. Date shows control measures are persistently outside of control limits. Components of a Water Management Program: Control limits for each control measure at each control location determine control limits, including the maximum value, minimum value or range of values of a chemical or physical parameter that shall be monitored and maintained in order to reduce hazardous conditions. Monitoring, establish a system for monitoring the parameters associated with the control limits. Examples of chemical and physical control measures and limits to reduce the risk of Legionella growth: measuring water quality throughout the system to ensure that changes that may lead to Legionella growth (such as a drop in chlorine levels) are not occurring. Maintaining water heaters at appropriate temperatures. Maintaining and regularly monitoring disinfectant and other chemical levels in cooling towers and hot tubs. Surfaces with any visible biofilm (i.e. (example) slime) should be cleaned. The facility's Water Management Program Committee Protocol-SNF (Skilled Nursing Facility) policy, not dated, documents, A water management program is in place to reduce the risk for Legionnaires disease and other potential diseases that may be associated with the building of water systems and devices. This program identifies areas or devices where bacteria, such as Legionella might grow or spread to people. The water management program committee will review all the above as well as the control measures used to maintain a safe water provision for residents, staff, families, and visitors. The committee consists of but is not limited to the following people: Administrator, Director of Nursing, Infection Preventionist, Maintenance Supervisor. Items reviewed are: all points flushed every month for 2 minutes, aerators, shower wands disinfected every six months, ice machine cleaned monthly, chlorine test completed by local water department, Infection Preventionist and control log reviewed for upper respiratory infections and outcomes, and employee infection record reviewed monthly.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, interview and record review the facility failed to include a resident's wish to eat in their room for 15 residents (R2, R4, R8, R11, R20, R21, R28, R32, R38, R39, R41, R47, R50, R53, R58) of twenty residents who have indicated that they wish to eat in their room instead of the main dining room for meals in a total sample of thirty eight. Findings include: The Facility's Comprehensive Care Plan policy dated 08/26/2025 documents The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. Throughout the survey the following residents were observed eating meals in their rooms during meal times: (R2, R4, R8, R11, R20, R21, R28, R32, R38, R39, R41, R47, R50, R53, R58) On 5/27/2026 V8 (Cook) provided a handwritten list of residents that usually eat their meals in their rooms instead of the main dining room. The list included: (R2, R4, R8, R11, R20, R21, R28, R32, R38, R39, R41, R47, R50, R53, R58) R2, R4, R8, R11, R20, R21, R28, R32, R38, R39, R41, R47, R50, R53, R58 care plan do not include any mention that these residents prefer to eat in their rooms during meal times. On 5/28/2026 V1 (Administrator) confirmed that the listed residents' care plans do not include their wish to eat in their rooms. V1 stated that should be on there (care plan).		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to inspect and regularly check the mattress and bed rails for areas of possible entrapment for 3 (R2, R6, and R8) of 3 residents reviewed for bedrails in a sample of 38. 1. R2's Medical Record documents she was admitted on [DATE] with diagnosis to include but not limited to Morbid Obesity, Type II Diabetes Mellitus and Chronic Respiratory Failure with Hypoxia. R2's Medical Record documents she cognitively intact and makes her own decisions. Throughout the survey R2's upper half side rails on both sides were up while she was in bed. On 5/27/2026 R2 stated she used the side rails for turning in bed. R2's Side Rail assessment dated [DATE] documents the side rails do not restrict mobility or prevent independent functioning. R2's Side Rail Assessment documents the side rails are used for increased mobility in bed. R2's Medical Record did not document any Entrapment Risk assessment for R2's side rails. 2. R6's Medical Record documents she was admitted on [DATE] with diagnosis to include but not limited to Osteoarthritis, Atrial Fibrillation and Dementia. R6's Medical Record documents that she is cognitively impaired and does not have good short term memory. Throughout the survey R6's upper half side rails on both sides were up while they were in bed. On 5/28/2026 during cares R6 used the side rails to assist in turning herself from side to side in bed. R6's Side Rail assessment dated [DATE] documents the side rails do not restrict mobility or prevent independent functioning. R6's Side Rail Assessment documents the side rails are used for increased mobility in bed. R6's Medical Record did not document any Entrapment Risk Assessment for R6's side rails. 3. R8's Medical Record documents she was admitted on [DATE] with diagnosis to include but not limited to Bipolar, Post Traumatic Stress Disorder and Encephalopathy. R8's Medical Record documents she is cognitively intact and makes her own decisions. Throughout the survey R8's upper half side rails were up when she was in bed. On 5/28/26 R8 reported she uses the half rails to help turn herself in bed. R8's Medical Record does not contain any Entrapment Risk Assessment for R8's side rails.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately reflect a resident's injection and insulin status related to the Minimum Data Set assessment for 1 (R21) of 24 residents in a sample of 38. Findings include:R21's admission Record indicates R21's diagnoses. Diabetes Mellitus is not listed as a diagnosis.R21's Quarterly MDS (Minimum Data Set) assessment dated [DATE] documents in section N0300. Injections R21 received 7 injections in a week. Section N0350. Insulin documents R21 received 7 insulin injections in a week. R21's Order Summary Report does not document a physician order for insulin injections. On 5/28/2026 at 9:30 AM, V2 (Director of Nursing) stated V2 could not find documentation in R21's electronic health record confirming R21 has received insulin injections since admission to the facility or has any current or past orders for insulin injections.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to monitor a resident's condition after return from the hospital for one resident (R2) of four residents reviewed for hospitalizations in a total sample of thirty eight. R2's Medical Record documents she was admitted to the facility on [DATE] with diagnosis to include acute and Chronic Respiratory failure with Hypoxia, Type II Diabetes Mellitus, Congestive Heart Failure and Hypertension. R2's Progress Notes dated 11/25/2025 document 2 was being sent to the emergency room for abnormal Hemoglobin. R2's admission assessment dated [DATE] documents she returned from the hospital after hospitalization for low Hemoglobin that was treated with blood transfusions. R2's Medical Record does not contain any other follow up or mention of R2's condition after hospitalization. On 5/28/2026 V2 (Registered Nurse/Director of Nursing) confirmed there was no ongoing monitoring of R2 by nurses after her hospitalization. V2 stated, (R2) should have had assessments for three days after she got back, if everything is stable then we would not continue. I don't know why (R2) has no documentation of ongoing assessment.		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to put a splint on as ordered for one resident (R6) of one resident reviewed for positioning/mobility in a total sample of thirty eight. R6's Medical Record documents she was admitted on [DATE] with diagnosis to include but not limited to Bipolar, Post Traumatic Stress Disorder and Encephalopathy. R6's Physical Therapy Discharge summary dated [DATE] documents, (R6) exhibits good improvements in right ankle range of motion. Correspondence with primary caregivers (facility staff) to facilitate development and follow-through of patient's plan and discussed equipment needs in preparation for next level of care. The facility's Training Acknowledgement training sign in sheet documents the topic as correct donning right AFO (Ankle Foot Orthosis). Put on Right AFO in the morning and remove before bed. for (R6). Throughout the survey R6 did not have a splint on her ankle. On 5/28/2026 R6 stated she wasn't sure if she was supposed to have a splint on any part of her legs or feet. R6 stated, I did for a while but I'm not sure anymore. I cannot remember when I last had it. On 5/28/2026 V15 (Certified Nurse Aide) confirmed she was the staff member responsible for R6's cares on this day. V15 (CNA) stated she did not know if R6 should have a splint on or not. V15 did confirm that R6 did not have any sort of splint on today 5/28/2026 or yesterday 05/27/2026.		

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. Based on interview and record review the facility failed to ensure prompt communication between Hospice Services and the facility for one resident (R6) of three residents reviewed for Hospice Services in a total sample of thirty eight. The Facility's Hospice Services Agreement signed and dated 8/1/2023 documents Hospice personnel shall provide all necessary oversight of services provided to Residents in accordance with the Hospice Plan of Care. Hospice shall review documentation of such services and shall communicate weekly Facility personnel to ensure that the needs of Residents are met in a comprehensive, coordinated fashion twenty-four hours a day. Such communication shall be documented pursuant to Hospice Policy. R6's Medical Record documents she was admitted to the facility on Hospice Services on 12/10/2024. R6's diagnosis include but are not limited to Congestive Heart Failure, Atrial Fibrillation, and history of Myocardial Infarction. R6's Medical Record documents she cognitively impaired and has short term memory problems. On 5/27/2026 V17 (Certified Nurse Aide) stated Hospice staff usually give R6 her bed bath/shower. It is a holiday week though, so I am not sure when they are coming or if they have already been here. On 5/28/26 V16 (Hospice Registered Nurse) stated she does not document in the facility's Electronic Medical Record at all. V16 (RN) reported that her office faxes her notes to the facility. V16 did not know where the Hospice CNAs would document where showers or any other cares given would be documented for communication to facility staff. On 5/28/2026 V6 (Registered Nurse) stated, Hospice faxes us lots of stuff, we put it right there (a box marked medical records by the fax/copy machine) and someone eventually scans it into the medical record. R6's Medical Record did not contain any information scanned from hospice to indicate what cares Hospice has provided when they were in the facility.		