

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146097	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2025
NAME OF PROVIDER OR SUPPLIER El Paso Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>33973</p> <p>Based on interview and record review the facility failed to maintain the privacy of residents' health information for six of six residents (R5, R11, R40-R43) reviewed for confidentiality/privacy in a sample of 43.</p> <p>Findings include:</p> <p>The undated Residents' Rights for People in Long-Term Care Facilities documents Your rights to privacy and confidentiality - You have a right to privacy and confidentiality of your personal and medical records. Your medical and personal care are private.</p> <p>The facility's undated Employee Handbook Acknowledgment Form includes but is not limited to the following: 507 - Non-Disclosure of Resident or Community Information: HIPAA (Health Insurance Portability and Accountability Act of 1996) grants significant privacy rights to our residents concerning the use or disclosure of their medical information. It is the policy of the Community to protect the privacy of Protected Health Information (PHI), and to ensure that such information is used and disclosed appropriately and in accordance with all applicable laws and regulations. PHI (Protected Health Information) is all individually-identifiable health information, including demographic information, collected from the resident or created or received by a health care provider a health plan, the resident's employer, or a health care clearinghouse and that relates to (i) the resident's past, present, or future physical or mental health or condition; (ii) the provision of health care to the resident; or (iii) the past, present, or future payment for the provision of health care to the resident. This information can be received and stored by the Community in many forms including faxes, e-mails, and all other electronic communications. It is important to remember that not every team member or resident's family has the right to access PHI.</p> <p>An anonymous undated group phone text message that was included in the complaint to State Agency documents a snapshot of six residents' dietary information cards. The residents' identified on these cards are R5, R11, R40, R41, R42, and R43 displaying their first and last names, room numbers and diet information. This phone text message documents the group involves 16 people.</p> <p>(continued on next page)</p>

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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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 2/5/25 at 1:30PM, V1 Administrator stated, I termed a CNA/Certified Nursing Assistant (V22) for not creating a good work environment. V1 stated staff had text messages with names indicated but could not provide any proof; V1 gave an in-service to staff on 1/29/25 about HIPAA. I told staff if there was a group text messaging going around, they needed to delete it if they have names or health information because that was a HIPAA violation, but I was unable to find any proof of that. I also told staff they would be terminated if found.</p> <p>On 2/5/25 at 3:05pm, V1 Administrator stated (V22) said she had text messages but was never able to provide me with any text messages of residents.</p> <p>On 2/11/25, at 11:52 am V22 CNA stated V22 was on the group text that displayed the residents' dietary information cards and then V22 blocked it. V22 stated that there were 16 people, all CNAs, not all of them still work here now, but did at that time. V22 is unsure of who put the snapshot of the dietary cards on the group message.</p> <p>On 2/7/25, at 11:19 am, R38 stated that her personal/health information is no one's business and that she wouldn't want it shared. R38's clinical record documents R38 is cognitively intact.</p> <p>On 2/7/25, at 11:21 am, R37 stated R37 would not want her personal /health information shared because it is private. R37's clinical record documents R37 is cognitively intact.</p> <p>On 2/7/25, at 2:3PM, V1 confirmed the group text message including six residents' diet cards displaying their full names, room numbers and diet information. At this time V1 said V1 cannot say whether having residents' names, room numbers and diet information on a group chat is a HIPAA violation. V1 stated I will need to ask Corporate.</p> <p>On 2/7/25, at 3:10pm V2 Director of Nursing/DON stated that having residents' full names, dietary information, and room numbers on a group chat is absolutely a HIPAA violation. V2 stated that a HIPAA violation is patient information that shouldn't be shared and should be protected.</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>33970</p> <p>Based on record review and interview the facility failed to ensure 2 residents (R11 and R31) were free from resident to resident physical abuse of seventeen residents reviewed for abuse in a total sample of 43.</p> <p>Findings Include:</p> <p>The Facility's Abuse, Prevention and Prohibition Policy dated 12/2024 documents Each resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff or their agencies serving the resident, family members or legal guardians, friends or other individuals.</p> <p>The Facility's Abuse, Prevention and Prohibition policy dated 12/2024 documents the definition of abuse as means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being, Instance of abuse of all residents, irrespective of any mental or physical condition, cause harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled using technology. Resident to Resident abuse includes the term willful. The word willful means that the individual's action was deliberate (not inadvertent or accidental), regardless of whether the individual intended to inflict injury or harm,</p> <p>The final abuse notification report to the state agency dated 10/8/2024 documents Brief Description of Incident: Allegedly (R17) made unwanted physical contact with (R11). Immediate Action Taken: (R17) and (R11) were immediately separated. (R17) went to ER (emergency room) for psych evaluation. Conclusion: A thorough investigation was completed by the facility. This investigation included interviews with staff and residents and chart review. The investigation showed that (V11) came out of her room and told (R17) to stay out of her (R11's) room. (R17) pushed (R11).</p> <p>R11's SBAR (Situation/Background/Assessment and Review) Communication Form dated 10/08/24 documents Resident pushed up against wall by another resident and fell to the ground. Did not hit head.</p> <p>On 2/11/25 at 10:30 AM R11with a BIMS (Brief Interview Mental Status) of 14 (cognitively intact) confirmed that a couple of months ago (R17) pushed her causing her to fall. Men should not be allowed on our hallway at all. R11 was unable to remember if there were any instigating factors prior to R17 pushing her. I don't know what his problem was.</p> <p>An abuse notification to the state agency dated 11/26/24 documents Brief Description of Incident: On 11/26/24 at 1800 (6:00 PM) (R34) and (R31) were in the dining room for dinner. Unwanted physical contact happened between the two. Investigation initiated. Final to follow. Immediate action taken: (R34) and (R31) were separated, and police were called and (R34) and (R31) are being sent to hospital. POA (Power of Attorney) and physician notified.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/11/25 at 1:00 PM R31 with a BIMS of 15 (indicating cognitively intact) stated (R34) did not like me trying to help pick up the meal tickets for (dietary staff) and he started yelling at me and he pushed me. He pushed me pretty hard, but I didn't fall.</p>