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	03/18/2025

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 0600 Level of Harm - 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. 30678 Based on observation, interview, and record review the facility failed to prevent resident to resident physical abuse by a known perpetrator for two (R22 and R23) of 13 residents reviewed for abuse in the sample of 36. This failure resulted in R22 hitting R23 in the mouth which caused R23 to suffer bleeding from her mouth. Findings include: The facility Abuse, Prevention, and Prohibition policy and procedure, 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 of other agencies serving the resident, family members or legal guardians, friends, or other individuals. Abuse - means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish and means the individual must have acted deliberately, not that the individual must have intended to inflict, injury or harm. An example of a deliberate (willful) action would be a cognitively impaired resident who strikes out at a resident within his/her reach, as opposed to a resident with a neurological disease who has involuntary movements (e.g., muscle spasms, twitching, jerking, writhing movements) and his/her body movements impact a resident who is nearby. This policy also documents that all instances of abuse, even those residents in a coma, can cause physical harm, pain, or mental anguish. The Final Report to the State Agency, dated 1/1/2025, documents, Original Complaint: It was reported to the abuse coordinator on 12/27/24 of an alleged physical altercation. While in the dining room (R22) allegedly struck (R23). The Account of events documents R22 and R23 were sitting in the dining room, R23 put her hand on R22's shoulder and began shouting. (R22) appeared to be startled, stood up and started to flail arms. Staff were present and in between residents at the time of the event to deescalate the situation. Remaining staff cleared dining room to ensure the safety of all other residents. R22 does not recall the incident and denies hitting anyone. (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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F 0600 Level of Harm - Actual harm Residents Affected - Few	The facility's undated Abuse Investigation documents a physical altercation occurred in the dining room with R22 striking R23. No injuries to R23. R23 approached R22, tapped R22's shoulder and yelled out. R23 stood up startled and began swinging his arms. Staff were immediately between the two residents. R22 did hit a staff member. All staff have interviews included in the investigation. The staff interviews for V4 CNA, V10 CNA, V35 CNA, and V43 CNA document they witnessed R22 attempting to hit staff members. V4 CNA witnessed R22 hit R23 and V35 CNA. V9 RN (Registered Nurse) documented multiple staff stated R22 hit multiple staff members and (R23). The investigation documents other residents were removed from the dining room. V1 Administrator's Abuse Investigation does not include names of potential staff and resident witnesses, tablemates, or who was in the dining room at the time of the altercation. The Investigation includes random Resident Abuse Allegation Interviews which include three non-specific abuse questions as: 1. Has a peer ever become physically aggressive toward you in the past week; 2. If yes, who did you notify; 3. Do you feel safe? These statements all document No to questions number one and two and yes to question number three. Due to questions asked it is not possible to determine if they had witnesses or specific details regarding the actual incident between R22 and R23. The Clinical Record for R22, includes the following diagnoses: Schizoaffective Disorder, Alcohol Dependence with Alcohol - Induced persisting dementia, Mild Neurocognitive Disorder, Insomnia, and Severe Manic Episode with Psychotic symptoms. R22 has severe cognitive impairment and history of verbal and physical behaviors directed towards others. The current Care Plan for R22 documents R22 with history of behavioral problems exhibited by verbal and physical aggression. A Physician Progress Note for R22, dated 2/12/25 at 4:04 pm, documents: R22 with psychotic disorder in ETOH (ethyl alcohol) induced Dementia. (R22) remains on 1:1 supervision due to his highly impulsive behaviors and mood swings. This note also documents R22 is erratic in mood. The Progress Notes for R22, dated 12/27/24 at 7:52 am, documents R22 receives one-to-one monitoring with staff. In the dining room waiting for breakfast (R22) and another resident were talking, other resident touched (R22's) arm, (R22) escalated very quickly, and hit other resident in the face. Multiple staff members are present and attempted to redirect (R22). (R22) continued to hit two other staff members in the face. (R22) then left the dining room, with his 1:1 staff and went to couch to lay down. Administrator, Physician, and local Law Enforcement were notified. Local Law Enforcement took statements and (R22) was sent out to a local hospital for evaluation. 12/27/24 at 10:16 am, R22 returned from the local hospital with no new orders and continued with one-to-one staff. The Clinical Record for R23, includes the following diagnoses: Schizoaffective Disorder, Bipolar II Disorder, Drug Induced Subacute Dyskinesia, Delusional Disorders and Chronic Obstructive Pulmonary Disease. R22 is cognitively intact. The current Care Plan for R23 documents R23 with a history of behavioral problems of yelling, cursing at staff, exit seeking, refusing medications, verbal, and physical aggressions, making false accusations, and attention seeking. The Progress Notes for R23, dated 12/27/24 at 7:48 am, documents R23 stated I touched peer and said hi, peer then back slapped me. Residents were immediately separated. Incident was witnessed by staff. Resident was assessed and no bruises or lumps noted at that time. 12/27/24 at 9:13 am, Resident came into SS (social service) office to discuss how they were doing. Resident stated that they were doing fine but still upset. SS will continue to follow up with resident. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 3/14/25 and 3/18/25 between 8:00 am through 4:30 pm, R22 had a staff member assigned to do one-to-one monitoring and noted to be walking about the facility independently. On 3/18/25 at 10:05 am, V35 CNA stated she was R22's one-to-one monitor on 12/27/24 and was sitting in the dining with R22. (R23) was also at the table and reached over and touched (R22) on the shoulder and started yelling. (R22) stood up and was swinging his arms. R22 did hit (R23) in the mouth and she was bleeding. R22 also hit V35 in the arm. V35 CNA stated she put all the information in her statement. On 3/18/25 at 10:12 am, V10 CNA stated she did not see (R22) hit (R23) but did see blood on R23's nose. There were multiple staff already dealing with the incident so (V10) just helped get residents out of the dining room. On 3/18/25 at 10:40 am, V9 RN (Registered Nurse) stated It was a big incident. Stated she did not witness the incident just heard that R23 tapped R22's shoulder and R22 freaked out. After reading her typed interview, V9 RN confirmed that there were multiple staff who stated R22 hit multiple staff and hit R23. On 3/18/25 at 11:26 am, V4 Social Service Assistant stated she was in the dining room, heard someone yell and when looked saw R22 stand up really quick and his arms went up. V4 stated she thinks someone got hit and heard R22 hit R23 but did not see it happen. V35 CNA was at the table, another nurse and there were residents but does not remember who they all were. On 3/18/25 at 1:43 pm, V44 Agency RN stated she was working the day the fight happened in the dining room between R22 and R23. R22 was sitting at the end of the table with a resident on each side of him. R23 was on R22's right side. R23 said she went to rub R22's arm and R22 flipped out and stood up. R22 back handed her in the face. I had never seen him lash out like that before. R23 did tell (V1 Administrator) that R22 hit her. (R22) also hit three or four staff who were right there. The dining room was evacuated and R22 calmed down and stopped being belligerent. Oh yes he meant to hit her. It was very willful. He was angry. R22 hit R23 two times, hit V35 CNA, and another staff member. The police did come and R22 did go out to the hospital and came back later that same day with no new orders. On 3/18/25 at 1:32 pm, V1 Administrator stated she is the Abuse Coordinator, she did the investigation for the physical altercation between R22 and R23. V1 stated the altercation occurred in the dining room. R23 reported she put her hand on R22's shoulder, yelled and R23 raised his arms up. V1 Administrator stated V35 CNA said R22 stood up and had hit (R23) and a staff member. V1 Administrator confirmed R22 did hit R23 and stated, no injuries were noted that I can recall.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 30678 Based on interview and record review the facility failed to complete a thorough abuse investigation for three (R22, R23, and R31) of 13 residents reviewed for abuse in the sample of 36. Findings include: The facility Abuse, Prevention, and Prohibition Policy, dated 12/2024, documents Resident abuse must be reported immediately to the Administrator. The facility Administrator will ensure a thorough investigation of alleged violations of individual rights and document appropriate action. Complete a thorough investigation. Two management level staff will conduct interviews with witnesses or other staff, residents or visitors who could have knowledge of the allegation. Witnesses will be asked to assist with completing statements if indicated. Every employee will be interviewed who was working on the specific hall/wing that the affected resident resides on. If the allegation occurred on a specific shift, all staff for the identified shift only will give a statement if indicated. 1. The Final Report to the State Agency, dated 1/1/2025, documents, Original Complaint: It was reported to the abuse coordinator on 12/27/24 of an alleged physical altercation. While in the dining room (R22) allegedly struck (R23).The Account of events documents R22 and R23 were sitting in the dining room, R23 put her hand on R22's shoulder and began shouting. (R22) appeared to be startled, stood up and started to flail arms. Staff were present and in between residents at the time of the event to deescalate the situation. Remaining staff cleared dining room to ensure the safety of all other residents. R22 does not recall the incident and denies hitting anyone. The facility Abuse Investigation documents a physical altercation occurred in the dining room on 12/27/24 between R22 and R23 alleging R22 striking R23. The investigation includes random staff and resident interviews were included on Staff Interview forms and Resident Abuse Allegation Interview forms. This investigation documents other residents were removed from the dining room and does not include potential staff or resident witnesses, table mates, or who was in the dining room at the time of the altercation. The Staff Interview forms ask four generic questions as: 1. Do you have knowledge of the alleged abuse? If so, describe; 2. What actions, if any, did you take in response to the allegation; 3. Did you report the alleged abuse? Who did you report it to? 4. What is 1:1 supervision? The random staff interview answers are handwritten on this form and then the answers are typed out by V1 Administrator for each staff person interviewed if they give details. The Resident Abuse Allegation Interview forms lists three non-specific abuse questions as: 1. Has a peer ever become physically aggressive toward you in the past week? 2. If yes, who did you notify?; 3. Do you feel safe? These random Resident interviews all document No to questions 1 and 2 and yes to question 3. There is no resident identified as witnessing the altercation between R22 and R23 during the meal service and no documentation of what residents observed during the meal service on 12/27/24. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/18/25 at 10:05 am, 10:12 am, 10:40 am, and 11:26 am, and 1:43 pm, V35 CNA, V10 CNA, V9 RN, and V4 Social Service Assistant, and V44 RN respectively stated staff write a statement and V1 Administrator types the interview out. On 3/18/25 at 1:32 pm, V1 Administrator stated she is the Abuse Coordinator and did not witness the altercation between R22 and R23 in the dining room on 12/27/24. V1 Administrator stated R23 reported she put her hand on R22's shoulder, yelled and R23 raised his arms up. V1 Administrator stated V35 CNA said R22 stood up and had hit (R23) and a staff member. V1 Administrator confirmed R22 did hit R23 and stated, no injuries were noted that I can recall. On 3/18/25 at 2:04 pm, V1 Administrator stated she always interviews staff and residents. V1 stated Social Service has helped with getting interviews. The Abuse Allegation Interview forms go out to the residents and come back to (V1). V1 stated the questions on the Abuse Allegation Interview forms are what is asked for the resident interviews. V1 Administrator stated she does not know who witnessed the altercation between R22 and R23, she did not have a list of witnesses for the incident, and confirmed she should know who witnessed is so-as-to interview them. V1 stated she does not keep the handwritten statements after typing them up. 2. On 3/7/25 at 10:35 am, V1 Administrator was informed by State Agency in the building of an allegation of V6 Consultant constantly calling R31 fat/ugly/broke/and to put a bra on. V1 stated, I have never had any complaints on (V6) or seen (V6) be inappropriate to the residents. (V6) mostly stays in my office. (R31) does not wear a bra. Is there an allegation? I don't have any reports with (V6 and V31), this is the first I am hearing of this; I will start an abuse investigation. The Initial Report dated 3/7/25 and the undated Final Report to the State Agency documents, Original Complaint: During the complaint survey (3/07) surveyor reported an alleged verbal/mental abuse allegation towards R31. There is no other documentation on the Initial or Final regarding the details of the allegation. The facility undated Abuse Investigation documents Staff to resident alleged verbal abuse. This Investigation documents R31's interview as: asked this resident if she has had any concerns with staff/male staff, resident states no. Asked resident if she was staff member by the name of (V6 Consultant), resident stated no. Resident stats she does not know this person, she has not had any concerns and she feels safe. The interview for V6 Consultant documents (V6) denies these allegations. The interview for V12 CNA documents Employee states she had no knowledge of this allegation. Employee states V6 Consultant is barely around residents. The Staff Interview forms ask three generic questions as: 1. Have you witnessed staff to resident mental/verbal abuse; 2. If yes, did you report it; 3. Who is your abuse coordinator? The random staff interview answers are handwritten on this form. All random staff answered No to question number 1, wrote nothing to question number 2, and wrote yes to question number 3. There is no further documentation as to questions regarding the allegation of abuse. These interview forms do not list detailed specific questions related to the verbal/mental abuse allegation. The Resident interview forms list three non-specific abuse questions as: 1. Has a staff member ever been mentally or verbally abusive to you? 2. If yes, did you report it?; 3. Do you feel safe? All random residents interviewed answered No to question number 1, answered NA or wrote nothing to question number 2, and answered Yes to question number 3. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/7/25 at 11:30 am, R31 was alert and oriented in the dining room sitting with other tablemates, dressed, and clean with no bra on. On 3/7/25 at 1:45 pm, R31 was lying in bed and stated (V6) has never called her fat, ugly, broke or to put a bra on. At that same time, R31 also stated she does not know who (V6) is; and staff and residents tell her she is fat, ugly, broke and to put a bra on all the time, but V12 CNA was not one of them. R31 also stated she does not like to wear a bra, so she doesn't. On 3/18/25 at 3:45 pm, V1 Administrator stated she understand the concern and confirmed her abuse investigation does not include detailed interviews from staff and residents regarding the physical altercation between R22 and R23 and the verbal/mental abuse allegation regarding R31. V1 stated going forward she would be detailed and ask specific questions with interviewing residents and staff versus using the facility interview form.

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F 0689 Level of Harm - Minimal harm or potential for 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** 33973 Based on observation, interview, and record review the facility failed to ensure continuous one-to-one supervision for one known physically aggressive resident (R22) of three residents reviewed for supervision in a sample of 36. Findings include: The facility's In-Service documentation titled, What Is 1:1 Supervision? dated 01/15/25, included the following bullet points: Resident should NEVER be out of sight; You should always be with the resident, resident should never be left unattended. R22's Physician/Practitioner Note, dated 02/12/25, documents Complaint: psychotic disorder in ETOH (Ethyl alcohol) induced dementia. HPI (History of Present Illness): [AGE] year-old male with ETOH induced Dementia with target behaviors of physical aggression towards others. He is not able to consent for his own meds and in the process of getting a State Guardian. He remains on 1:1 supervision due to his highly impulsive behaviors and mood swings. R22's clinical record documents the following diagnoses: Other Schizoaffective Disorder; Alcohol dependence with alcohol induced persisting dementia; Mild Neurocognitive Disorder due to known physiological condition with Behavioral Disturbance; and Manic episode, severe with psychotic symptoms. On 3/11/25 at 8:05am, R22's room door was closed, R22 was in his room and not visible from the hallway. V16 and V17 CNAs/ Certified Nursing Assistants Entered R33's room across the hall and transferred R33, from his wheelchair to his bed, utilizing a full-body mechanical lift. V16, CNA stated she was assigned to do one-to-one Supervision of R22 at the time. On 3/11/25 at 8:23am V16 CNA stated R22 is on one-to-one observation status 24 hours, 7 days a week. V16 verified R22 was in his room with the door closed and was not visible from the hallway. V16 stated R22 requires one-to-one observation due to physical aggression towards others and impulsive behaviors. On 3/12/25 at 8:40am, V2 DON/Director of Nursing stated when a resident is on one-to-one observation, staff must keep the resident within eyesight. V2 stated there is no policy addressing one to one resident observation. V2 stated V1 Administrator did give an in-service on one-to-one Supervision. On 3/18/25, at 3:45pm V1 Administrator confirmed that R22 is on one-to-one supervision and is not to be out of the staff person's sight. V1 stated that whoever did that will be fired.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 33973 Based on observation, interview, and record review the facility failed to ensure a resident's indwelling urinary catheter tubing was secured in place for one (R1) of three residents reviewed for indwelling urinary catheters in a sample of 36. Findings include: The facility's undated Catheter Care, Urinary policy documents Changing Catheters 2. Ensure that the catheter remains secured with a leg strap to reduce friction and movement at the insertion site. (Note: Catheter tubing should be strapped to the resident's inner thigh.) R1's current Physician Order Sheet documents R1 has an indwelling urinary catheter. On 3/11/25, at 12:09pm, R1 sat in a wheelchair in her room. An indwelling urinary catheter tubing was hanging out of R1's incontinent brief with a clasp dangling on the tubing; tubing was not secured to R1's leg. At this time R1 stated This one is supposed to be strapped to my leg, but it isn't today. I am not okay with it because sometimes it gets yanked. On 3/11/25, at 3:21pm, R1 was lying in bed with an indwelling urinary catheter draining into a catheter bag. V14 Certified Nursing Assistant/CNA confirmed there is no leg strap, and she should have one. On 3/11/25, at 3:23pm, V3 Assistant Director of Nursing/ADON stated that resident urinary catheters should have a stabilizer for the tubing.