

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  04/29/2025
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 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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49187</p> <p>Based on interview and record review, the facility failed to ensure a resident was free from physical abuse for one of three residents (R2) reviewed for abuse in a sample of six.</p> <p>Findings include:</p> <p>The facility's Abuse, Prevention and Prohibition Policy, dated 3/2025, documents Statement of intent: 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. Resident to Resident Altercations: 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. An example of a deliberate (willful) action would be a cognitively impaired resident who strikes out a resident within his/her reach, as opposed to a resident with a neurological disease who has involuntary movements (example: muscle spasms, twitching, jerking, writhing movements) and his/her body movements impact resident who is nearby. Definitions: Abuse- means the willful infliction of injury, unreasonable confinement, intimidation, or punishment 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, or physical condition cause harm, pain, or mental anguish. It includes verbal abused, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled using technology. Physical Abuse- includes, but is not limited to, hitting, slapping, punching, biting, and kicking.</p> <p>R1 and R2's Final Five-Day Reported Incident to Illinois Department of Public health, dated 3/26/25, documents (R2) states (R1) was upset over having a towel, words were exchanged and then (R1) open handed struck (R2).</p> <p>A typed form dated 3/21/25 and signed by V14/Social Service Director, documents (R5) states she asked (R1) if he found towels, (R5) states (R1) cursed. (R2) then shouted at (R1) and (R1) hit (R2) on top of the head.</p> <p>R1's Face Sheet documents R1 is a [AGE] year-old-male admitted to the facility on [DATE] with the following but not limited to diagnoses: Schizoaffective Disorder, Bipolar Disorder, Major Depressive Disorder, and Dementia with Moderate Agitation.</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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R1's MDS (Minimum Data Set) Assessment, dated 3/31/25, documents R1 is severely cognitively impaired.</p> <p>R1's current Care Plan documents (R1) has a behavioral problem related to Schizoaffective Disorder, Bipolar Disorder, Major Depressive Disorder, and Dementia. Verbal aggression, physical aggression, refuses meals a times, refuses assessments, refuses nail trimming, refuses medications, and refuses cares. This same plan of care documents R1 is an identified offender and has been determined to be moderate risk.</p> <p>R1's Criminal History Analysis Security Recommendation Report, dated 2/26/23, documetns (R1) is moderate risk. (R1) requires closer suprevison and more frequent observations than standard or routine for most residents in an open facility. Regular Monitoring should be attentive to behavior changes that may signal a need for closer observation or sustained visual monitoring on a time-limited basis. Periodic assessments should ascertain whether the level of supervision is sufficient.</p> <p>R1's SBAR (Situation, Background, Assessment, and Recommendation) Communication Form, dated 3/21/25 and signed by V10/LPN (Licensed Practical Nurse) documents (R1) involved in a physical altercation with another resident (identified as R2) and hit (R2) on top of the head. This same form documents (R1) is aggressive and not tolerating (R2).</p> <p>R2's Face Sheet documents R2 is a [AGE] year-old-male with the following but not limited to diagnoses: Major Depressive Disorder and Anxiety Disorder.</p> <p>R2's MDS Assessment, dated 3/12/25, documents R2 is cognitively intact.</p> <p>R2's Progress Note, dated 3/21/25 and signed by V10/LPN, documents This nurse was informed that (R2) was attacked by another resident (identified as R1). (R2) was hit on top of his head.</p> <p>R5's MDS Assessment, dated 4/18/25, documents R5 is cognitively intact.</p> <p>On 4/29/25 at 10:25 AM R1 verbalized he does not recall any situation where he hit another resident. R1 stated, I have a mental disorder, I am not going to remember doing something like that.</p> <p>On 4/29/25 at 10:45 AM R2 stated, I was sitting across from the nurse's station and (R1) and I had an argument. When we were arguing (R1) reached out and hit me on top of my head. I didn't like it, so I immediately started yelling for someone to help me. A staff member (I don't remember their name) came out and removed R1 away from me.</p> <p>On 4/29/25 at 11:06 AM V10/LPN stated, A little over a month ago I was passing medications down the hallway when I heard (R2) screaming help he's been hit. When I got to (R2) he stated (R1) had hit him on top of the head. (R5) was sitting by (R2) at this time and stated she witnessed (R1) hit (R2) on top of the head.</p> <p>On 4/29/25 at 12:40 PM R5 stated, (R1), (R2), and me were all sitting across from the nurse's station around a month ago. I asked (R1) if he had found towels yet to take a shower. (R1) told me not to worry about it. (R2) told (R1) not to talk to me like that. (R1) got mad and went over to (R2) and hit (R2) on top of the hit. (R2) then started screaming for help. (R2) was upset. I witnessed the entire thing.</p>		