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	08/08/2025

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record review and interview the facility failed to follow the facility's Discharge/Transfer policy for 1 resident (R2) of 3 residents reviewed for hospitalizations in the sample of 22.Findings include:The facility's policy Discharge/Transfer Out Checklist (undated) documents: SBAR (Situation Background Assessment Recommendation) assessment completed prior to calling the provider. Provider order obtained and entered in (electronic health record) to send to ER (Emergency Room)/hospital.R2's medical record documents R2's diagnoses include, but not limited to: Paranoid Schizophrenia, Major Depression Disorder, and Hypertension. R2's medical record documents: Resident complains of multiple episodes of loose stool, nausea and abdominal pain, resident able to make needs known, requested to be sent to the hospital. DON (Director of Nursing) informed; resident sent to (hospital) 3:00 pm via ambulance for further evaluation. Resident is own self POA (Power of Attorney). On 8/1/25 at 11:50 AM R2 verified that he went to the emergency room recently, however R2 unable to provide any details of encounter.On 8/1/25 at 12:21 PM V3 (Assistant Director of Nursing) verified that facility Discharge/Transfer Out Checklist is what the facility uses as the policy. V3 confirmed that nurses are to complete SBAR (Situation Background Assessment Recommendation) form and call the emergency room with report when a resident is being sent to the hospital. V3 verified that R2 did not have an SBAR completed for his transfer to the emergency room on 7/10/25.On 8/1/25 at 1:48 PM V2 (Registered Nurse) verified that she sent R2 to the emergency room on 7/10/25 and she does not recall if she phoned the emergency room and provided report of resident condition to an emergency room nurse. V2 verified she is aware that SBAR (Situation Background Assessment Recommendation) form should be completed prior to sending a resident to the emergency department for evaluation.The facility was not able to provide any type of documentation regarding the transfer On 8/5/25 V3 (Assistant Director of Nursing) verified that there is not an order from the physician to send R2 to the emergency room for evaluation on 7/10/25. V3 stated, We were not aware that it was in our policy to obtain an order from the physician to send a resident to the emergency room for an evaluation.

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
	146097	A. Building B. Wing	08/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
El Paso Health Care Center	850 East Second Street El Paso, IL 61738

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0803 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0803 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow diet orders for residents who receive mechanical soft diets, failed to document residents' noncompliance with mechanically altered diets, and failed to educate facility staff on residents who are on mechanically altered diets. These failures resulted in R1, who has a history of choking and requiring the Heimlich Maneuver, being able to purchase snacks from V5 (Medical Records) that were not part of R1's physician ordered diet texture. These failures have the potential to affect all 20 residents (R1, R4 through R22) who reside in the facility that receive a mechanically altered diet.These failures resulted in an Immediate Jeopardy that began on 7/12/25. While the Immediate Jeopardy was removed on 8/08/25, the facility remains out of compliance at a severity level two. Additional time is needed to monitor the effectiveness of the implementation of protocols and oversight visits.Findings include: The facility Inservice Training Handout: Understanding Diet Types in Skilled Nursing Facilities (SNFs), not dated, documents, Mechanical Soft Diet (Mechanically Altered) Definition: Soft, moist foods that require minimal chewing. Meats are ground or finely chopped. No hard, crunchy, or sticky textures. Important Guidelines: Always follow speech-language pathologist recommendations. Do not serve foods outside of resident's prescribed texture level. Use visual cues, consistency checks, and documentation.The facility training policy, titled What is a texture Modified Diet, not dated, documents, Mechanically altered or soft diets is used when there are problems with chewing and swallowing. Changes the consistency of a regular diet to a softer texture. Includes chopped or ground meats as well as chopped or ground raw fruits and vegetables. Foods to avoid on a Mechanical Soft Diet: Nuts and seeds, non-ground meats, breads with hard crust, hard candy, and raw, crunchy fruits and vegetables.R1's admission record documents R1's date of admission to the facility was 8/9/22 and his diagnoses included: Diabetes Mellitus due to underlying condition without complications, Dementia in other diseases classified elsewhere moderate with agitation, Hyperlipidemia, Personal History of Transient Ischemic Attack (TIA), and Cerebral Infarction without residual deficits.R1's Minimum Data Set (MDS) assessment, dated 7/1/25, documents R1 has a Brief Interview for Mental Status (BIMS) score of 9/15, indicating moderate cognitive impairment.R1's progress notes dated 7/12/25 documents, RN (Registered Nurse) called to dining room with reports of Resident choking RN reported to the dining room, observed resident sitting in chair at table and taking several bites of food without swallowing between bites, color is good, V/S (vital signs) stable, afebrile, breath sounds are clear to auscultation bilaterally, SAO2 (arterial oxygen saturation) 98% (percent) on room air, resident reports I don't know why I choked this was the first time that has happened. RN completed assessment and remained with the resident to observe eating pattern and noted that resident was eating fast and taking several bites of salad without swallowing after each bite, RN encouraged resident to swallow after each bite and to follow up with a drink of water before taking additional bites, resident demonstrated appropriate swallowing. Dr. (doctor) V6 informed at 2000 (8:00pm), POA (Power of Attorney) (V7), brother notified at 2010 (8:10pm) per phone conversation, RN contacted (Contracted Diagnostic Company) services for STAT (immediate) chest X-Ray, spoke with (Contracted Diagnostic Company) staff, STAT chest X-Ray ordered. Facility manager on duty, V3 (Assistant Director of Nursing/ADON) notified.On 8/5/25 at 10:30am, V8 (Certified Nursing Assistant/CNA) stated, I was serving the supper meal in the dining room when I heard another resident yell 'He's choking.' I immediately went to R1 and saw that he was unable to breathe so I got him (R1) to stand up and performed the Heimlich Maneuver on him. It took approximately four good thrusts before a small piece of food was dislodged and he started coughing so I stepped back and let him continue and he was able to cough up the rest of the lettuce up by himself (R1) and began breathing and talking. After I knew he (R1) was ok I went and got his nurse who completed an assessment on him.R1's facility SBAR (Situation, Background, Assessment, Recommendation) Communication Form and progress note dated 7/12/25, documents, resident (R1) had a swallowing issue.R1's Physician Orders dated 7/14/25 document that R1's diet was changed to CCD (Controlled Carb Diet) diet Mechanical Soft texture, Regular/Thin consistency, no lettuce, or green leafy vegetables for diet related to Diabetes Mellitus due to underlying condition without complications.R1's current care plan documents, (R1) is a risk for aspiration and choking related to impaired swallowing function evidenced by actual choking incident requiring Heimlich Maneuver and (R1) requires a modified diet (mechanical soft) with thin liquids.R1's Incident Report for Choking/Emergency Intervention dated 7/12/25, documents at approximately 6:45pm R1 choked requiring the Heimlich Maneuver. R1 was assessed post