

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 08/19/2025
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>Based on interview and record review, the facility failed to notify a resident's family of a resident's return from the hospital for one of three residents (R1), reviewed for family notification, in a sample of 5. FINDINGS INCLUDE: The facility policy, Significant Condition Change and Notification, dated 12/2024 directs staff, To ensure that the resident's family and/or representative and medical practitioner are notified of resident changes such as: Transfer of the resident. Calls will be made to the resident's representative until they are reached. Each attempt will be charted as to the time the call was made, who was spoken to, and what information was given. R1's electronic medical record documents R1 was transferred to the local emergency room on 8/1/25 at 3:12 A.M. after experiencing increased behaviors and delusions. R1'S Nursing Progress Notes, dated 8/1/25 document, 8/1/2025 (R1) back from hospital at approximately 10:30 A.M., yelling and agitated and crying out, refused vitals, did report that she will run again. On 8/18/25 at 10:35 A.M., Z10/R1's Family Member stated, I am (R1's) guardian due to her mental health. They (facility staff) called me to tell me (R1) was running away and they had called the police and were having (R1) taken to the hospital. But no one ever called me to tell me (R1) came back (to facility). It wasn't until I called them (facility) on (8/2/25) and asked them, did I know what had happened to (R1). They (facility) are supposed to call me and let me know. On 8/19/25 at 1143 A.M., V1/Administrator verified that R1's mother (Z1) had not been called by facility staff to alert her that R1 had returned to the facility.</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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>Based on interview and record review, the facility failed to update a plan of care after a resident made repeated attempts, on two different days, to elope from the facility, for one of one resident (R1), reviewed for care plans, in a sample of 5.FINDINGS INCLUDE:The facility policy, Care Planning, dated 12/2024 directs staff, Purpose: To address each resident's strengths, weaknesses and care needs. To use this assessment data to develop a comprehensive plan of care for each resident that will assist a resident in achieving and maintaining the highest practical level of mental functioning, physical functioning and wellbeing as possible. R1's Nursing Progress Notes, dated 7/29/25 at 3:35 P.M. document, (R1 is experiencing a change in condition. (R1) left building through the front door.Resident has had no further behaviors or attempts to exit building.R1's Nursing Progress Notes, dated 8/1/25 at 2:54 A.M. document,(R1) was observed by CNA (Certified Nursing Assistant) walking down the hallway, and turning towards the common room. A few seconds after it was observed by nurse on camera that (R1) was attempting to exit the facility. Writer, other nurse on floor, and (other staff) ran to front door as (R1) was observed walking out the door and into the parking lot. (R1) continued to walk forward and push past staff down the street and past the stop sign. (R1) continued to walk and push forward, while yelling throughout and became violent and combative swinging closed fists at nearby staff. (R1) repeatedly attempted to swing and physically assault staff. MD (Physician) was contacted and order received to send to hospital for psych (psychiatric) evaluation. Police were also then contacted as the facility staff was unable to get (R1) safely back to building. (R1) transported to local hospital.R1's Care Plan, dated (revised) 5/27/25 includes the following Focus Area: (R1) is an elopement risk/wanderer. This same plan of care includes the following Interventions: 4/10/25 Distract (R1) from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. 5/1/25 Monitor for fatigue and weight loss. 5/27/25 Calmly redirect (R1) and remind her that this is her home. Find a task, activity or simply a conversation to engage her in. No further interventions were implemented after R1's elopement from the facility on 7/29/25 or 8/1/25, were developed by the facility staff. On 8/19/25 at 1:10 P.M., V10/Care Plan Coordinator verified R1's care plan was not revised after R1's recent attempts on 7/29/25 or 8/1/25 to leave the facility unattended. At that time, V10 stated that the facility management team should have reviewed R1's plan of care after each elopement attempt and implemented new interventions to reduce the risk of R1 leaving the facility.</p>		