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	04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
El Paso Rehabilitation and 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 - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observation, interview, and record review, the facility failed to ensure residents were free from physical abuse for five of eight residents (R1, R3, R4, R7, and R9) reviewed for abuse in a sample of 9. The facility's Abuse, Prevention and Prohibition Policy, dated November 2025, 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. This form also documents that instances 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 facilitation or enabled using technology. Physical abuse includes, but is not limited to, hitting, slapping, punching, biting, and kicking. 1.R1's Brief Interview for Mental Status, dated 3/10/26, documents a score of 11, indicating that R1 is alert and oriented. On 4/10/26 at 12:15pm. R1 returned to her room from the dining room. R1 stated that there is a male who scares her. R1 stated that she had her hand resting on the corner of the table, and R2 came by and punched the top of her hand for no reason. R1 stated that every time R2 comes around, she leaves the area. R1 stated that her hand hurt really badly after R2 had hit it. R1 held out her hand, and there was swelling and slight discoloration noted of the middle finger and knuckles. The facility's Final Report, dated 4/3/26, documents that at approximately 10:45am it was reported that (R1) made the allegation that resident (R2) had made unwanted physical contact with her hand that was on a table in the dining hall. This form documents that an X-ray was completed and revealed a mildly displaced fracture. R1's X-ray dated 4/1/25, documents evidence of a mildly displaced fracture of the base of the first metacarpal bone. This form documents that there is reduced bone density seen and degenerative osteoarthritis changes in the small joints. R1's Progress Notes documented that R1 complained of generalized pain before the incident, but after she complained of pain in her left hand. R2's current care plan documents that R2 displays behavioral symptoms related to schizoaffective disorder, generalized anxiety disorder, and dementia, including refusal of care, responding to internal stimuli, and verbal or physical aggression when overstimulated. On 4/10/26 at 1:30 pm, V15, Certified Nursing Assistant, stated that she heard R1 yell Ouch, then said R2 hit me. V15 stated that R2 was propelling his wheelchair past R1 at the time, but she did not see him hit her. V15 stated that R1 was complaining of pain in her left hand. On 4/11/25 at 1:00pm, V3, Registered Nurse, verified that R1 complained of pain in her left hand after the incident with R2. 4/13/26 at 9:30am, V13, Medical Records, stated that heard R1 yell Ouch He hit me, and R2 was next to R1. 2. R7's Brief Interview for Mental Status, dated 1/22/26, documents a score of 11, indicating the R7 is alert and oriented. R7's Progress Notes, dated 3/15/26, documents that the resident (R7) is experiencing is resident was hit in the face with a plate by another resident in the dining room. R5's Brief Interview for Mental Status, dated 1/30/26, documents a score of 15, indicating the R5 is alert and oriented to person, place, and time. R5's current care plan documents that R5 exhibits physical aggression toward peers related to difficulty managing emotions, as evidenced by recent incidents of aggressive behavior toward other residents. The facility's Final Report, dated 3/24/26, documents (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Account: During the mid-day meal service, Resident 1 (R5) became acutely agitated. and exhibited signs of emotional distress. Staff initiated de-escalation interventions; however, the resident (R5) remained inconsolable. Resident #1 (R5) expressed a fixed belief that Resident #2 (R7) had made an offensive remark, though this could not be substantiated by staff or other residents present. This form documents that the investigation determined that a resident-to-resident incident occurred in which Resident #1 (R5), during a period of acute psychiatric distress and impaired perception, threw a plate that made contact with Resident #2 (R7). This form also documents that Resident #1 (R5) was transferred to the emergency department for further psychiatric evaluation and stabilization. On 4/10/26 at 12:45pm, R7 stated that she was sitting in the dining room, and R5 was talking very loudly about her sexual ideals. R7 stated that she got up and moved a couple of seats down from her, and she picked up her plate with food on it and threw it at her. R7 stated that it hit her on the right side of her face from her eyebrow to her cheek. R7 stated that she had a bruise for a while from the incident. On 3/13/26 at 8:45am, V4, Social Service Director, stated that R7 was talking to another resident when R5 said something to R7. V4 stated that a verbal altercation started, then R5 threw a lunch plate at R7. V4 verified that the plate hit R7 on the side of the face around her right eye to her cheek. V4 stated that R7 had a red line on her face from the plate. R4 stated that it took several staff to get R5 to calm down. V4 stated that it happened so fast that R5 could not be reached before she threw the plate. On 3/13/26 at 9:20am, V17, Certified Nursing Assistant, stated that R7 was talking with another resident when R5 chucked her plate full of food at R7. V17 stated that the plate hit her on the side of the face. V17 also stated that it took 3 staff to get R5 away from R7. On 3/13/26 at 9:40am, V16, Activity Aide, stated that she heard R5 and R7 yelling back and forth. V16 stated that R5 was telling R7 to shut up and leave. V16 stated that R7 then told R5 to leave, and R5 stood up and threw her lunch plate at R7, hitting her in the face. V16 also stated that staff were walking R5 out of the dining room, when she attempted to lunge at R7 again. 3. R3's electronic medical record documents a diagnosis of Disorganized Schizophrenia, Obsessive-Compulsive Personality Disorder, and Borderline Personality. R3's Brief Interview for Mental Status, dated 3/11/26, documents a score of 12, indicating the R3 is alert and oriented. R3's Progress Notes, dated 3/20/26, document that R3 was standing too close to another resident's (R5) boyfriend. This form documents that R5 hit R3 in the back area and was told, Do not touch him. R3 was not aware why R5 hit her. The facility's Final Report, dated 3/25/26, documents that the investigation determined that a resident-to-resident physical altercation occurred, initiated by Resident #1 (R5) striking Resident #2 (R3). The findings indicate that Resident #1 (R5) demonstrates impaired impulse control and behavioral dysregulation. This form also documents that Resident #2 (R3) was the recipient of the behavior with no contributing actions identified. R3 was observed several times throughout this survey walking in the halls, speaking, and laughing with staff and other residents. R3 did not display any adverse behaviors.R5's current care plan documents that R5 exhibits physical aggression toward peers related to difficulty managing emotions, as evidenced by recent incidents of aggressive behavior toward other residents. V18,s signed statement, dated 3/20/26, documents that R3 was walking around when she patted a resident on the back. V18 stated that R5 then hit R3 and said, Don't touch my boyfriend or me.On 4/13/26 at 10:50am, V14, Licensed Practical Nurse, stated that R3 was walking past the nurses' station where R5 was standing with another resident. V14 stated that R5 told R3 to get away from her, then R5 hit R3 in the lower stomach. 4. R4's Brief Interview for Mental Status, dated 12/16/25, documents a score of 15, indicating the R4 is alert and oriented to person, place and time. R4's Progress Notes, dated 3/17/26, documents that R4 was hit on the right side of the cheek by another resident (R6). The facility's Final Report, dated 3/20/26, documents that following a comprehensive review of the incident, the allegation was confirmed, as evidence showed that Resident #1 (R6) did strike (R4). R6's current care plan documents that R6 is vulnerable to peer conflict due to cognitive impairment and environmental triggers, with a history of resistance to resident altercations involving physical contact. This form also documents that R6 is at risk for resident-to-resident altercations (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	related to behavioral triggers and environmental factors. V19's, Certified Nursing Assistant, signed statement dated 3/17/26, documents that she was in the dining room and heard a scuffle. V19 turned around, and two residents (R4 and R6) were throwing punches at each other. On 4/10/26 at 1:30pm, R4 stated that he was sitting in the dining room, and another resident came up and hit him in the head for no reason. On 4/10/26 at 1:45pm, V15, Certified Nursing Assistant, was sitting outside of R6's room. V15 stated that R6 has been on one-on-ones for quite some time. V15 stated that R6 has poor impulse control. 5. The facility's Final Report, dated 4/6/26, documents that it was reported at approximately 10:00am that Resident #1 (6) made unwanted contact with Resident #2 (R9) dining/living room area. R6's Progress Notes, dated 4/1/26, document that R6 had a physical altercation with a female peer (R9). 911 was called, and R6 was sent to the emergency room for an evaluation. On 4/13/25 at 9:30am, V13, Medical Records, stated that both R6 and R9 were in line for vending day. V13 stated that R9 started to yell at R6 to hurry up, when R6 turned around and hit R9 in the face. On 4/13/26 at 1:30pm, V1, Administrator, stated that R6 was on one-on-ones for 72 hours after his first incident with R4, but did not exhibit adverse behaviors, so they were stopped. V1 verified that after the incident with R9, R6 will be on permanent one-on-ones. V1 stated that because of the client population, it is impossible to stop every resident-to-resident incident.