

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 06/10/2026
NAME OF PROVIDER OR SUPPLIER El Paso Rehabilitation and 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)		
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on interview and record review the facility failed to ensure a resident's right by insisting residents provide a two week notice prior to a home visit, for two of five residents (R28 and R90), reviewed for resident rights, in a sample of 36. Findings include: The facility form, Acknowledgement of Resident Responsibilities, provided and signed by each resident upon admission documents, Resident Planned Absences from the Facility: Competent residents may leave the facility at any time for outings after signing out. The facility must be provided information on the time leaving, estimated return and location of the outing. A friend or family member must accompany residents who are not competent. Those residents leaving for overnight outings must have a current physician order. Medications will be provided for the overnight stay. The facility may notify the resident or authorized representative that the payment program that the resident is currently approved for may prohibit an overnight stay. No requirement for residents to provide a two weeks' notice is present. On 6/08/2026 at 9:43 A.M., during the facility Resident Council Meeting, R28 stated that facility staff told him that when he wanted to go on an overnight outing, he was required to give them a two week notice so they could get his medications set up, for him to take with. At that time, V90 also confirmed he and his family were also informed they had to give the facility a two week notice prior to leaving for an overnight visit, to prepare his medications. On 6/08/2026 at 10:18 A.M., V6/Social Services Director (SSD) stated when residents request to go on a home visit, the resident tells social services or the family calls social services and lets them know what dates the resident will be out of the facility. V6/SSD states the facility requests a two week notice due to notifying the pharmacy to get medications. When asked who instituted the two weeks' notice policy, V6/SSD stated, facility management. On 6/08/2026 at 10:22 A.M., V8/Licensed Practical Nurse (LPN) stated when a resident goes on a home visit, social services let the nurse know and the nurse places the required medications into pill packets, along with instructions for use, for the resident to take home. States one resident (R90) requires a special pre-filled card that comes from the pharmacy, due to his pain control arrangement. States pharmacy staff deliver to the facility daily in the evening, but will deliver at noon also, if needed. States no medications take two weeks to obtain from the pharmacy. On 6/08/2026 at 1:32 P.M., V2/Director of Nurses (DON) confirmed that nurses were instructed to inform residents that requested an overnight outing, provide the facility nurses with a two weeks' notice, so medications could be obtained from the pharmacy. At that time, V2/DON confirmed the facility received medications regularly from the pharmacy, up to two times daily and she was uncertain why the two weeks' notice was required.		

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 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents have reasonable access to and privacy in their use of communication methods. Based on interview and record review, the facility failed to distribute mail on Saturdays for three of five residents reviewed (R15, R28 and R90) for mail delivery, in a sample of 36. Findings include: The facility Resident Rights booklet, provided to all residents upon admission to the facility documents, Your rights to privacy and confidentiality: Your facility must deliver and send your mail promptly. On 6/08/2026 at 9:43 A.M., during the facility Resident Council Meeting, R15, R28 and R90 all voiced concerns that facility residents only receive packages on Saturday, but they do not receive any mail. At that time, R15 stated he had important personal mail that he had been waiting for and had to wait until Monday mornings, when business office staff were present in the facility, to receive his mail. On 6/08/2026 at 10:26 A.M., V7/Activity Assistant (AA) stated resident mail comes to the facility and is delivered to the business office staff. The business office staff sort through the mail, and then give it to the Activity staff, for resident distribution. V7/AA stated activity staff are present each weekend, but business office staff were not. Therefore residents get packages on Saturday, but only get mail delivery on Monday through Friday. On 6/08/2026 at 10:35 A.M., V5/Administrative Assistant (AA) stated the facility business office manager is off on medical leave at this time. V5/AA stated that facility mail is delivered to the business office, business office staff go through the mail and take out all facility mail and then give the mail to Activity staff for resident distribution. States business office staff are not in the facility on weekends, typically. At that time, V5/AA confirmed that facility residents do not receive mail on Saturdays.		

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F 0600 Level of Harm - Minimal harm or potential for 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident was free from verbal and physical abuse for one of two residents (R14) reviewed for abuse in a sample of 36. Findings include: The facility's Abuse, Prevention and Prohibition Policy, dated 01/24, 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. Policy: This facility prohibits mistreatment, neglect, or abuse of residents. This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. This presumes that all instances of abuse, even those residents in a coma, can cause physical harm, pain, or mental anguish. This same policy documents, Definitions: Abuse- means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. 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 facilitated or enabled using technology. R14 and R53's Initial Reported Incident to Illinois Department of Public Health, dated 5/24/26, documents It was reported to the abuse coordinator (V1/Administrator) at approximately 6:10 PM that (R53) made unwanted physical contact with (R14) during the evening mealtime. R14 and R53's Final Five-Day Reported Incident to Illinois Department of Public Health, dated 5/29/26, documents Original Complaint: It was reported to the Abuse Coordinator (V1/Administrator) at approximately 6:10 PM that (R53) made unwanted physical contact with (R14) during evening mealtimes. This same Report documents, Determination; Following completion of the investigation, the allegation was substantiated, as evidence confirmed that (R53) struck (R14) in the face during the altercation. An Occurrence Interview Form dated 5/24/26 and signed by V18/CNA (Certified Nursing Assistant), documents (R53) began yelling at (R14) as (R53) exited the dining room calling (R14) Gay, fat, ugly without being provoked. (R53) kept getting closer to (R14) as a dietary employee was attempting to keep them separated, I approached to de-escalate the situation. (R53) hit (R14) in the face and (R14) tried to get near (R53) but could not be due to myself and other staff members blocking her way. (R14) sat back down [NAME] other staff members removed (R53) who was still attempting to attack (R14).An Occurrence Interview Form dated 5/24/26 and signed by V17/CNA, documents (R53) walked out of the dining room into the from room yelling and calling (R14) names. (R53) stopped and continued to call (R14) names and was provoking (R14) to fight. When (R14) stood up and walked up to (R53), I (V17) was physically in the middle trying to keep distance in between them when (R53) started to fight (R14), then (R14) tripped trying to get to (R53).R14's admission Record documents R14 is a [AGE] year-old female who admitted to the facility on [DATE] with the following, but not limited to, diagnoses: Bipolar Disorder, Major Depressive Disorder, Anxiety Disorder, and Pervasive Developmental Disorder.R14's MDS (Minimum Data Set Assessment), dated 5/1/26, documents R14 is cognitively intact.R14's Progress Note, dated 5/24/26 and signed by V23/LPN (Licensed Practical Nurse) documents The change in condition (R14) is currently experiencing is (R14) was hit in her face in nose area by another resident (identified as R53).R53's (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	admission Record documents R53 is a [AGE] year-old female who admitted to the facility on [DATE], with the following, but not limited to, diagnoses: Bipolar Disorder, Major Depressive Disorder, and Pseudobulbar Affect.R53's MDS Assessment, dated 5/1/26, documents R53 is cognitively intact.R53's Progress Note, dated 5/24/26 and signed by V19/LPN, documents (V19) did not witness this incident. It was reported by staff that (R53) had a physical altercation with another resident (identified as R14).On 6/9/26 at 2:26 PM V18/CNA stated During the evening meal, (R53) began yelling at (R14) as (R53) was leaving the dining room. (R53) started calling (R14) fat, ugly, a b***h, you name it. (R53) was walking closer to (R14) so (R14) stood up. I then got between (R53) and (R14). (R53) started swinging her arms and was able to get one hit on (R14, smacking (R14) on the left side of (R14)'s face. (R14) and (R53) were finally able to be separated. (R14) was upset from getting hit.On 6/10/26 at 9:35 AM R14 stated, I was sitting by the dining room. (R53) got up out of nowhere and started walking towards me calling me a fat cow, fat b***h, and a c***t. I got up and told (R53) to leave me alone. After I said that (R53) smacked me in my nose. It hurt me and upset me because (R53) knows better.On 6/10/26 at 10:10 AM V17/CNA stated, after dinner I was walking with (R53) to walk (R53) back to her room. As we are walking, (R53) turns to (R14) and starts yelling at (R14) stating (R14) was the reason no one likes (R53). (R53) called (R14) a b***h, called her big, and a pig. (R14) then started yelling at (R53) stating she is always crying and to leave (R14) alone. (R53) started walking towards (R14), (R14) then stood up, and I got in between both (R14) and (R53). I have my right arm back trying to hold (R14) back because I am facing (R53). (R53) shoved me, then started swinging at (R53). (R53) ended up slapping (R14) in the face once as I was trying to intervene.I was walking with (R53) after dinner to assist them back to their room. During the walk, (R53) turned to (R14) and began yelling, claiming that (R14) was the reason nobody liked them. (R53) called (R14) a 'b***h,' 'big,' and a 'pig.' (R14) then yelled back, telling (R53) that they were always crying and to leave them alone. When (R53) started coming toward (R14), (R14) stood up. I immediately stepped between them, facing (R53) while extending my right arm backward to hold (R14) back. (R53) shoved me, began swinging wildly, and managed to slap (R14) once in the face while I was actively trying to intervene.On 6/10/26 at 11:13 AM (R53) stated, (R14) has made a few remarks about my daughter in the past. My daughter has cancer and (R14) thinks it's funny so I don't like her. I don't want to talk about what happened in the dining room.		

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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 interview and record review the Facility failed to issue written notification for hospital transfers/discharges to Resident/Resident's Representatives for three of 19 Residents (R5, R14 and R45) reviewed for hospital transfer/discharge in a sample of 36. Findings include: The Facility Bed Hold Policy, dated 4/2026, documents: before the Facility transfers a Resident to a hospital or the Resident goes on therapeutic leave, the Facility will provide written information to the Resident and/or Resident Representative that specifies the duration of the state bed-hold policy, reserve payment policy in the state plan and the bed-hold period; all information provided to a Resident and/or Representative requires a signature of receipt of the policy by the Resident and/or Representative including bed hold information; and documentation could include a copy of the notice, progress notes or transfer list. 1. R5's Census Record, undated, documents R5's Hospital Paid Leave dates of 1/4/26 and 1/26/26. R5's Nursing Progress Notes, dated 1/4/26 and 1/26/26, document that R5 had a change of condition and was transferred to the local hospital for evaluation and treatment. Written notification to R5 and/or V21 (R5's Responsible Party) was not documented. 2. R14's Census Record, undated, documents R14's Hospital Paid Leave dates of 1/20/26 and 3/20/26. R14's Nursing Progress Notes, dated 1/20/26 and 3/20/26, document R14 had a change of condition and was transferred to the local Hospital for evaluation and treatment. Written notification to R14 and/or V20 (R14's Responsible Party) was not documented. 3. R45's Census Record, undated, documents R45's Hospital Paid Leave dates of 1/29/26, 2/9/26 and 5/14/26. R45's Nursing Progress Notes, dated 1/28/26, 1/29/26, 2/9/26 and 5/14/26, document R45 had a change in condition and was transferred to the local Hospital for evaluation. Written notification to R45 (R45's Responsible Party) was not documented. On 6/10/26 at 9:10 am, V2 (Director of Nursing) stated, I cannot find any written notifications to responsible party or Residents when they are transferred to the hospital. On 6/10/26 at 10:02 am, V6 (Social Service Director) stated, I am responsible for providing the written notification of discharges to the responsible party's or Residents upon discharge and I have not provided any written notification of discharges.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation and record review, the facility failed to ensure a resident who developed a new open skin area received immediate clinical assessment, timely physician notification, and necessary medical orders per facility policy for one of two residents (R4) reviewed for wounds in a sample of 36. Findings include: The facility's Skin Identification, Evaluation, and Monitoring Policy, dated 2/2026, documents Purpose: The purpose of this policy is to outline a method of identification, evaluation and monitoring for alterations in skin integrity. Communities will implement preventive measures, and an individualized care plan will be formulated upon completion of findings. Procedure: A licensed nurse will evaluate skin integrity through a physical skin evaluation upon admission, weekly, and when a significant change is identified. The nursing assistant will observe the resident's skin when assisting with activities of daily living and report changes to the nurse. Licensed Nurses will evaluate the resident's risk for skin breakdown using the Braden Risk Assessment tool upon admission, weekly for three consecutive weeks (totaling 4), quarterly, and when a significant change is identified. The Certified Nursing Assistant: D. Report skin integrity changes to nurse. Licensed Nurse Weekly: b. If new wound is identified: i. Initiate protective dressing, ii. notify health care provider for further treatment orders. c. Document evaluation in the medical record. R4's admission Record documents R4 is a [AGE] year-old male who admitted to the facility on [DATE] with the following, but not limited to, diagnoses: Type Two Diabetes Mellitus, Chronic Kidney Disease (stage 3), Peripheral Vascular Disease, Acquired Absence of Right Leg Above Knee, and Lymphedema. R4's MDS (Minimum Data Set) Assessment, dated 3/13/26, documents R4 is cognitively intact and requires substantial/maximal assistance with rolling left to right. R4's Skin Check Assessment, dated 5/30/26, documents, R4 had no skin issues to R4's coccyx. R4's Skin Check Assessment, dated 6/9/26 with an effective date of 6/8/26, documents R4 has an open lesion to R4's coccyx. On 6/9/26 at 10:00 AM R4's Physician Order Sheets, Progress Notes, or Skin Assessments does not document any skin assessment, orders, or physician notification of R4's open lesion identified on 6/8/26. On 6/8/26 at 1:35 PM V14/CNA (Certified Nursing Assistant) and V15 (CNA) prepared to provide R4 incontinent care. During R4's incontinent care, R4 complained of pain while being cleaned up on R4's coccyx. R4 had a pea size red open area observed to R4's coccyx area. V14 and V15 both verified at this time that the area was open. On 6/9/26 at 11:22 AM V14 stated she reported to R4's open area to R4's coccyx to V16/LPN (Licensed Practical Nurse) on 6/8/26 right after cares were provided and the open area was identified. V14 stated she never witnessed V16 come down and assess R4's open to R4's coccyx. On 6/9/26 at 11:34 AM V16/LPN (Licensed Practical Nurse) V16 confirmed that V14/CNA reported a coccyx wound on R4 the previous day. V16 noted that while her initial visual check on 6/8/26 revealed no open areas, V14 reported the issue again the following morning. During R4's shower on June 9, V16 reassessed the resident and identified the open wound on the coccyx. V16 admitted that she had not yet measured the wound, documented a skin assessment or progress note, or notified the physician. Additionally, V16 acknowledged that she failed to have V14 or V15 point out the exact location of the wound on June 8 after her own initial assessment came up negative or type a progress note of her assessment on 6/8/26. On 6/9/26 at 10:45 AM V2/Director of Nursing stated that R4's open area should have been investigated the previous day (6/8/26). V2 noted that staff should have located the wound, completed a comprehensive wound assessment with measurements, and obtained a treatment order. Furthermore, V2 verified that no wound assessment or progress notes had been completed or entered into the system for R4 as of that time. On 6/9/26 at 11:00 AM V3/Wound Nurse (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	verified that V16 was responsible for measuring R4's wound and initiating immediate treatment. V3 noted that V16 should have investigated why they did not observe an open area, especially since V14 and V15 (both CNA's) identified the wound that same day. Furthermore, V3 clarified that V16 was required to enter a progress note regarding the assessment, regardless of whether a wound was visible.		

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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. Based on observation, interview, and record review the facility failed to ensure a resident's indwelling urinary catheter drainage bag remained below the level of the bladder during transfers and routine care for one of one resident (R4) reviewed for urinary indwelling catheters in a sample of 36. Findings include: The facilities Urinary Catheter Care Policy, dated 12/2024, documents The purpose of this procedure is to prevent catheter-associated urinary tract infections. Maintaining Unobstructed Urine Flow: 3. The urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder. R4's current Care Plan documents R4 has the following, but not limited to, diagnoses: Type Two Diabetes Mellitus, Chronic Kidney Disease (stage 3), and Neuromuscular Dysfunction of Bladder. This same Care Plan documents R4 has an indwelling urinary catheter. On 6/8/26 at 1:25 PM two Certified Nursing Assistants (V14 and V15) prepared to transfer R4 from a wheelchair to the bed using a mechanical lift to perform catheter care. During the transfer preparation, V14 placed R4's indwelling urinary catheter drainage bag onto the R4's lap. While setting up the mechanical lift, V15 took the drainage bag from R4's lap and secured it to one of the lift's loops. V14 and V15 then proceeded to transfer R4 into the bed. After the transfer, V14 removed the urinary catheter drainage bag from the lift sling and set it directly on R4's bed. The drainage bag remained on the bed throughout the duration of R4's urinary catheter and incontinence care. On 6/9/26 at 11:22 AM V14/CNA verified R4's indwelling catheter bag was placed on R4's lap, then attached to R4's mechanical lift sling during R4's transfer on 6/8/26. R4 verified the indwelling catheter bag was then placed on the bed during R4's catheter care and incontinence care. On 6/9/26 at 11:34 AM V2/Director of Nursing stated R4's urinary catheter drainage bag should have been maintained below R4's bladder and should not have been placed on R4's lap or on R4's bed.		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide the posted diet for three of three residents (R15, R28 and R90), in a sample of 36. The undated facility policy, Menu Substitutions or Changes and Approval directs staff that menu changes are made for instances such as food delivery problems, food quality issues, planned special events or in disaster situations. The facility Spring/Summer Master Menu 2026- week 3 includes the following noon meal for Monday, June 8th: Wheat Roll, Turkey Cutlet and Gravy, Baked Potato, [NAME] Roasted Vegetables and Homemade Frosted Banana Cupcake. The noon meal for Tuesday, June 9th includes: Pork Carnitas and Cheese Quesadilla, Ranchero Beans, Cilantro Coleslaw and Yellow Cake/Chocolate Icing. On 6/08/2026 at 9:43 A.M., during the facility Resident Council Meeting, R15, R28 and R90 all voiced concerns that they only receive plain cake with no frosting or icing. On 6/08/2026 at 12:26 P.M., during an observation of the facility noon meal, R15, R28 and R90 's meal consisted of turkey cutlet, mashed potatoes and gravy, vegetables and a banana cupcake with no frosting. On 6/08/2026 at 12:45 P.M., V24/Dietary Manager (DM) confirmed R15, R28 and R90's banana cupcake had no frosting. At that time, V23/DM stated she would ask the cook why the cupcakes were plain and not frosted. On 6/09/2026 at 12:32 P.M., during an observation of the facility noon meal, R15, R28 and R90's meal consisted of a chicken taco, beans, coleslaw and a piece of plain yellow cake with no frosting or icing. On 6/09/2026 at 12:51 P.M., V24/Dietary Manager (DM) confirmed R15, R28 and R90's yellow cake did not have any chocolate frosting. At that time, V24/DM stated she would talk with the kitchen staff. On 6/10/2026 at 9:43 A.M., V1/Administrator stated the facility kitchen staff should always follow the established facility menu, including frosting or icing all cakes, cupcakes, brownies, as ordered.		