STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002745	A. BUILDING: _____ B. WING _____	C 03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EL PASO HEALTH CARE CENTER	850 EAST SECOND STREET EL PASO, IL 61738

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Original Complaint Investigations: 2521452/IL186887	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.1210b) 300.3210t) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002745	A. BUILDING: _____ B. WING _____	C 03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EL PASO HEALTH CARE CENTER	850 EAST SECOND STREET EL PASO, IL 61738

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 1	S9999		

care needs of the resident.

Section 300.3210 General

t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property.

These requirements were not met as evidenced by:

Based on observation, interview, and record review the facility failed to prevent resident to resident physical abuse by a known perpetrator for two (R22 and R23) of 13 residents reviewed for abuse in the sample of 36. This failure resulted in R22 hitting R23 in the mouth which caused R23 to suffer bleeding from her mouth.

Findings include:

The facility Abuse, Prevention, and Prohibition policy and procedure, dated 12/2024, 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." "Abuse - means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish" and "means the individual must have acted deliberately, not that the individual must have intended to inflict, injury or harm." "An example of a deliberate (willful) action would be a cognitively

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002745	A. BUILDING: _____ B. WING _____	C 03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EL PASO HEALTH CARE CENTER	850 EAST SECOND STREET EL PASO, IL 61738

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 2	S9999		

impaired resident who strikes out at a resident within his/her reach, as opposed to a resident with a neurological disease who has involuntary movements (e.g., muscle spasms, twitching, jerking, writhing movements) and his/her body movements impact a resident who is nearby." This policy also documents "that all instances of abuse, even those residents in a coma, can cause physical harm, pain, or mental anguish."

The Final Report to the State Agency, dated 1/1/2025, documents, "Original Complaint: It was reported to the abuse coordinator on 12/27/24 of an alleged physical altercation. While in the dining room (R22) allegedly struck (R23). "The Account of events documents R22 and R23 were sitting in the dining room, R23 put her hand on R22's shoulder and began shouting." (R22) appeared to be startled, stood up and started to flail arms. Staff were present and in between residents at the time of the event to deescalate the situation. Remaining staff cleared dining room to ensure the safety of all other residents." R22 does not recall the incident and denies hitting anyone.

The facility's undated Abuse Investigation documents a physical altercation occurred in the dining room with R22 striking R23. No injuries to R23. R23 approached R22, tapped R22's shoulder and yelled out. R23 stood up startled and began swinging his arms. Staff were immediately between the two residents. R22 did hit a staff member. All staff have interviews included in the investigation. The staff interviews for V4 CNA, V10 CNA, V35 CNA, and V43 CNA document they witnessed R22 attempting to hit staff members. V4 CNA witnessed R22 hit R23 and V35 CNA. V9 RN (Registered Nurse) documented multiple staff stated R22 hit multiple staff members and (R23). The investigation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002745	A. BUILDING: _____ B. WING _____	C 03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EL PASO HEALTH CARE CENTER	850 EAST SECOND STREET EL PASO, IL 61738

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 3	S9999		

documents other residents were removed from the dining room.

V1 Administrator's Abuse Investigation does not include names of potential staff and resident witnesses, tablemates, or who was in the dining room at the time of the altercation. The Investigation includes random Resident Abuse Allegation Interviews which include three non-specific abuse questions as: 1. Has a peer ever become physically aggressive toward you in the past week; 2. If yes, who did you notify; 3. Do you feel safe? These statements all document No to questions number one and two and yes to question number three. Due to questions asked it is not possible to determine if they had witnesses or specific details regarding the actual incident between R22 and R23.

The Clinical Record for R22, includes the following diagnoses: Schizoaffective Disorder, Alcohol Dependence with Alcohol - Induced persisting dementia, Mild Neurocognitive Disorder, Insomnia, and Severe Manic Episode with Psychotic symptoms. R22 has severe cognitive impairment and history of verbal and physical behaviors directed towards others. The current Care Plan for R22 documents R22 with history of behavioral problems exhibited by verbal and physical aggression.

A Physician Progress Note for R22, dated 2/12/25 at 4:04 pm, documents: R22 with psychotic disorder in ETOH (ethyl alcohol) induced Dementia. "(R22) remains on 1:1 supervision due to his highly impulsive behaviors and mood swings." This note also documents R22 is "erratic in mood."

The Progress Notes for R22, dated 12/27/24 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002745	A. BUILDING: _____ B. WING _____	C 03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EL PASO HEALTH CARE CENTER	850 EAST SECOND STREET EL PASO, IL 61738

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 4	S9999		

7:52 am, documents R22 receives one-to-one monitoring with staff. In the dining room waiting for breakfast (R22) and another resident were talking, other resident touched (R22's) arm, (R22) escalated very quickly, and hit other resident in the face. "Multiple staff members are present and attempted to redirect (R22). (R22) continued to hit two other staff members in the face. (R22) then left the dining room, with his 1:1 staff and went to couch to lay down." Administrator, Physician, and local Law Enforcement were notified. Local Law Enforcement took statements and (R22) was sent out to a local hospital for evaluation. 12/27/24 at 10:16 am, R22 returned from the local hospital with no new orders and continued with one-to-one staff.

The Clinical Record for R23, includes the following diagnoses: Schizoaffective Disorder, Bipolar II Disorder, Drug Induced Subacute Dyskinesia, Delusional Disorders and Chronic Obstructive Pulmonary Disease. R22 is cognitively intact. The current Care Plan for R23 documents R23 with a history of behavioral problems of yelling, cursing at staff, exit seeking, refusing medications, verbal, and physical aggressions, making false accusations, and attention seeking.

The Progress Notes for R23, dated 12/27/24 at 7:48 am, documents R23 stated "I touched peer and said hi, peer then back slapped me. Residents were immediately separated. Incident was witnessed by staff. Resident was assessed and no bruises or lumps noted at that time." 12/27/24 at 9:13 am, "Resident came into SS (social service) office to discuss how they were doing. Resident stated that they were doing fine but still upset. SS will continue to follow up with resident."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002745	A. BUILDING: _____ B. WING _____	C 03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EL PASO HEALTH CARE CENTER	850 EAST SECOND STREET EL PASO, IL 61738

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 5	S9999		

On 3/14/25 and 3/18/25 between 8:00 am through 4:30 pm, R22 had a staff member assigned to do one-to-one monitoring and noted to be walking about the facility independently.

On 3/18/25 at 10:05 am, V35 CNA stated she was R22's one-to-one monitor on 12/27/24 and was sitting in the dining with R22. (R23) was also at the table and reached over and touched (R22) on the shoulder and started yelling. (R22) stood up and was swinging his arms. R22 did hit (R23) in the mouth and she was bleeding. R22 also hit V35 in the arm. V35 CNA stated she put all the information in her statement.

On 3/18/25 at 10:12 am, V10 CNA stated she did not see (R22) hit (R23) but did see blood on R23's nose. There were multiple staff already dealing with the incident so (V10) just helped get residents out of the dining room.

On 3/18/25 at 10:40 am, V9 RN (Registered Nurse) stated "It was a big incident." Stated she did not witness the incident just heard that R23 tapped R22's shoulder and R22 freaked out. After reading her typed interview, V9 RN confirmed that there were multiple staff who stated R22 hit multiple staff and hit R23.

On 3/18/25 at 11:26 am, V4 Social Service Assistant stated she was in the dining room, heard someone yell and when looked saw R22 stand up really quick and his arms went up. V4 stated she thinks someone got hit and heard R22 hit R23 but did not see it happen. V35 CNA was at the table, another nurse and there were residents but does not remember who they all were.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002745	A. BUILDING: _____ B. WING _____	C 03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EL PASO HEALTH CARE CENTER	850 EAST SECOND STREET EL PASO, IL 61738

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 6 On 3/18/25 at 1:43 pm, V44 Agency RN stated she was working the day the fight happened in the dining room between R22 and R23. R22 was sitting at the end of the table with a resident on each side of him. R23 was on R22's right side. R23 said she went to rub R22's arm and R22 flipped out and stood up. R22 back handed her in the face. "I had never seen him lash out like that before." R23 did tell (V1 Administrator) that R22 hit her. (R22) also hit three or four staff who were right there. The dining room was evacuated and R22 calmed down and stopped being belligerent. "Oh yes he meant to hit her. It was very willful. He was angry." R22 hit R23 two times, hit V35 CNA, and another staff member. The police did come and R22 did go out to the hospital and came back later that same day with no new orders. On 3/18/25 at 1:32 pm, V1 Administrator stated she is the Abuse Coordinator, she did the investigation for the physical altercation between R22 and R23. V1 stated the altercation occurred in the dining room. R23 reported she put her hand on R22's shoulder, yelled and R23 raised his arms up. V1 Administrator stated V35 CNA said R22 stood up and had hit (R23) and a staff member. V1 Administrator confirmed R22 did hit R23 and stated, "no injuries were noted that I can recall." (B)	S9999		