Illinois Department of Public Health

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 02/23/2023

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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S 000	Initial Comments Complaint Investigation 2320520/IL155516 2320589/IL155611 2320658/IL155688 2320696/IL155720 2320906/IL155990 2321489/IL156691 2321503/IL156710	S 000		
S9999	Final Observations Statement of Licensure Violations (Violation 1 of 3) 300.510c) 300.510e) 300.610a) 300.1210b) 300.1210d)3) 300.3210t) 300.3240a) 300.3240f) Section 300.510 Administrator c) The administrator shall arrange for facility supervisory personnel to annually attend appropriate educational programs on supervision, nutrition, and other pertinent subjects. e) The licensee and the administrator shall be familiar with this Part. They shall be responsible for seeing that the applicable regulations are met in the facility and that employees are familiar with those regulations according to the level of their responsibilities.	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE   TITLE   (X6) DATE

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S9999	Continued From page 1 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 care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be	S9999		

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S9999	Continued From page 2	S9999		

made by nursing staff and recorded in the resident's medical record.

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.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act)

These requirements were not met as evidenced by:

Facility Failures Resulted in Two Deficient Practice Statements

A. Based on observation, interview and record review, the facility failed to ensure residents (R6, R10, R11, R18) were free from sexual and verbal abuse by R9, who had known history of sexually inappropriate behaviors towards females, for five of 12 residents reviewed for abuse in a sample of

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S9999	Continued From page 3 25. These failures resulted in R6 being groped in a sexual manner and verbally abused, experiencing psychological distress. Additionally, the facility failed to prevent known, ongoing sexual relations between R9 and R6, who is Intellectually Disabled, unable to consent, and has a State Appointed Guardian. The facility also failed to investigate an allegation of sexual abuse made by R6 against R9 (on 1/05/23) and protect R6 from potential further abuse, failed to investigate and implement measures to prevent an ongoing sexual relationship between a resident (R6, who lacks the mental capacity to legally consent) and R15, failed to investigate multiple allegations of abuse made by residents during Resident Council meetings, which included sexual abuse, verbal abuse, staff retaliation and misappropriation, and failed to investigate an allegation of verbal abuse made by R3 against V3 (Registered Nurse/RN) on 1/24/23. Additionally, the facility failed to investigate inner thigh bruising found on R1's inner thighs and facial bruising found on R5, both injuries of unknown origin. These failures have the potential to affect all 116 residents that reside in the facility, as no measures were taken by V1 (Administrator in Training/AIT) to ensure residents within the facility were protected from potential further abuse. B. Based on observation, interview and record review, the facility Administration failed ensure a safe living environment and quality care and services were provided to all residents, failed to provide leadership and institute their Abuse Prevention program and failed to have an effective, comprehensive approach to numerous significant resident concerns regarding the quality of resident life within the facility. The facility has been unable to maintain consistent Administrative leadership over the last 12 months. V1 (AIT)	S9999		

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S9999	Continued From page 4	S9999		

failed to respond to resident allegations of abuse, neglect and mistreatment. These failures have the potential to affect all 116 residents currently living in the facility.

Findings include:

A. The Facility Abuse Prevention Program policy (revised 11/28/2016) documents, "This facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, and exploitations defined below. This includes, but is not limited to, freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This facility therefore prohibits mistreatment, exploitation, neglect, or abuse of its residents, and has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent the occurrences of mistreatment, exploitation, neglect, or abuse of our residents. This will be done by: Conducting required pre-employment screening of employees; Orienting and training employees on how to deal with stress and difficult situations, and how to recognize and report occurrences of mistreatment, exploitation, neglect and abuse immediately to supervisory personal; Training on activities that constitute abuse, neglect, exploitation and misappropriation of resident property; Establishing an environment that promotes resident sensitivity, resident security and prevention of mistreatment, exploitation, neglect and abuse of residents and misappropriation of resident property; including, prohibiting staff from using any type of equipment to keep, distribute photographs and recording of residents that are demeaning or humiliating;

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S9999	Continued From page 5 Identifying occurrences and patterns of potential mistreatment, exploitation, neglect and abuse of residents and misappropriation of resident property; Dementia management and resident abuse prevention; Immediately protecting resident involved in identified reports of possible abuse; Implementing systems to investigate all reports and allegation of mistreatment, exploitation, neglect, abuse or residents and misappropriation of resident property; promptly and aggressively, and making the necessary changes to prevent future occurrences; and Procedures for reporting of potential incidents of abuse, neglect, exploitation or the misappropriation of resident property. This facility is committed to protecting our residents from abuse by anyone, including, but not limited to, facility staff, other residents, consultants, volunteers, and staff from other agencies providing services to the individual, family members or legal guardians, friends or any other individuals." Section IV of the policy documents, "Internal Reporting Requirements and Identification of Allegations: Employees are required to immediately report any occurrences of potential/alleged mistreatment, exploitation, neglect, and abuse of residents and misappropriation of resident property they observe, hear about, or suspect to a supervisor and the administrator. All residents, visitors, volunteers, family members or others are encouraged to report their concerns or suspected incidents of potential/alleged mistreatment, exploitation, neglect, and abuse of residents and misappropriation of resident property to a supervisor and administrator. Such reports may be made without fear of retaliation. Anonymous reports will also be thoroughly investigated. Supervisors shall immediately inform the administrator or his/her designated representative	S9999		

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S9999	Continued From page 6	S9999		

(specified by the administrator in the case of a planned absence) of all reports of potential/alleged mistreatment, exploitation, neglect, and abuse of residents and misappropriation of resident property. Upon learning of the report, the administrator or designee shall initiate an investigation. The nursing staff is additionally responsible for reporting on a facility incident report the appearance of bruises, lacerations, other abnormalities, or injuries of unknown origin as they occur. Upon report of such occurrences, the nursing supervisor is responsible for assessing the resident, reviewing the documentation and reporting to the administrator or designee. If the resident complains of physical injuries or if resident harm is suspected, the resident physician will be contacted for further instructions." Section V of the policy documents, "Protection of Residents: The facility will take steps to prevent mistreatment, exploitation, neglect, and abuse of residents and misappropriation of resident property while the investigation is underway. Residents who allegedly mistreat or abuse another resident or misappropriate resident property will be removed from contact with that resident during the investigation. The accused resident's condition shall be immediately evaluated to determine the most suitable therapy, care approaches and placement considering his or her safety, as well as the safety of other residents and employees of the facility. Accused individuals not employed by the facility will be denied unsupervised access to the resident during the course of the investigation. Employees of this facility who have been accused of mistreatment, exploitation, neglect, abuse or misappropriation of resident property will be immediately removed from resident contact until the results of the

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S9999	Continued From page 7	S9999		

investigation have been reviewed by the administrator or designee. Employees accused of alleged mistreatment, exploitation, neglect, abuse or misappropriation of resident property shall not complete their shift as a direct care provider to residents."

The facility policy, titled "Injuries of Unknown Origin (revised 4/18/16), documents "All injuries of Unknown Origin will be investigated to determine the potential cause of the injury. Upon identification of the cause, interventions will be established to prevent any further injury by the IDT (Interdisciplinary Team) or Administration. All Injuries of Unknown origin will be discussed at the daily (Quality Assurance) meeting." The policy advises, "Determine if the injury may be related to mistreatment of a resident: Bruising noted about the face or neck area; Bruising/reddened areas noted on wrists or lower forearms - similar to finger placement, or any part of the body that may indicate finger placement; Handprints/bruising noted to buttocks." The policy instructs staff to "Identify and establish interventions for prevention of any further injuries: Possible Abuse - Begin following Abuse Prevention Program."

A.1. R9's Pre-Admission Screening System, dated 11/18/21, from prior to R9's admission (11/24/21) to the facility and obtained from R9's medical records at the facility, documents, "Behavior Assessment Summary: (R9) is a 28-year-old male who was admitted to hospital due to being actively psychotic. (R9) has a history of hospitalizations and being aggressive. Behavior type: Antisocial behavior; Criminal justice system involvement; Fire setting or arson; Physical assault/injury threatening to others; Poor judgement placing self or others at risk; Property damage; Self injurious behaviors; Serious

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S9999	Continued From page 8	S9999		

wandering, elopement; Sexual aggression." A Cumulative Diagnosis Log (no date) documents R9 has the current diagnoses of Schizoaffective Disorder, Bipolar Type and Hypersexuality. A Minimum Data Set assessment, dated 11/30/22, documents R9 can ambulate independently.

A Final Incident Report to State Agency, dated 1/14/22, summarized that R9 had grabbed R6's breast as she was near the ice machine in the kitchen area, and R6's account of what had occurred was substantiated by resident interviews that had witnessed the incident.

R9's current Plan of Care documents (beginning 3/15/22) "(R9) has behaviors that others may find disruptive/socially inappropriate. Others may seek reprisal against the resident. Behavior exhibited sexually inappropriate, yelling out, verbal outbursts," and instructs staff "1 on 1 (at) all times when out of room and council on appropriate interactions (with) peers (and) staff as needed per his behaviors." The Care Plan also documents, R9 has displayed "verbal aggression, inappropriate touching, wanders, irregular thoughts." A Psychosocial Assessment, dated 11/30/22 identifies R9 has behaviors of being socially inappropriate, wandering, seducing/soliciting, seeking intimate contact, and masturbating.

Daily Resident Monitoring documents R9 was decreased from 1 on 1 supervision to "Resident Monitoring - 15 minutes - Staff (must) make visual contact with resident every 15 minutes" on the following dates: 12/15/22, 12/16/22, 12/17/22, 12/18/22, 12/20/22, 12/21/22, 12/23/22, 12/25/22, 12/26/22, 12/27/22, 12/30/22, 12/28/22, 12/31/22, 1/01/23, 1/02/23, 1/03/23, 1/04/23, and 1/05/23. All of R9's 15 Minute Monitoring reports

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S9999	Continued From page 9	S9999		

Continued From page 9

document his location as being in either the hallway, dining room, resident room, television room or patio. R9's medical record contains no documented rationale for decreasing his level of supervision to every 15-minute checks on those dates. Daily Resident Monitoring logs for the dates of 12/11/22, 12/13/22 and 12/14/22 indicate "Resident Monitoring - One to One," however, on those three dates the "One to One" is crossed out with an ink pen and R9's location is only documented every hour on the hour.

On 2/16/23 at 11:37 am, V9 (Unit Aide) clarified the December Resident Monitoring for R9, as her initials are on several of R9's monitoring logs. V9 was given R9's logs from 12/11/22, 12/13/22 and 12/14/22 and asked about the "One to One" that was crossed out on the top of the log sheet. V9 stated "There was, like a week in December when we took (R9) off 1:1 and he was just on every 15-minute checks, so the 'One to One' was crossed out on certain days so people would know he (R9) was not 1:1 on those days, but a every 15-minute check. I'm not sure who made that decision to decrease his supervision."

A Grievance/Complaint Report dated 1/05/23 and completed by V4 (Social Services), documents R6 complained "(R9) rubbing on her butt, putting arm around her (and) saying 'Baby, give me a kiss,' touched her breast, looked up her dress. Also, going up (and) down A Hall (at) night, (R6) claimed, 'I can hear (R9) through the wall.'"

Resident Council Meeting minutes dated 1/10/23 document resident complaints that "(R9) needs to be on a 1 on 1 at all times, overnights too. Residents are not comfortable in his presence and are scared of him. (R9 is) very violent, overly sexual, calling names, going through resident's

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S9999	Continued From page 10	S9999		

rooms, (R10, R6, R11 and R12) have all brought attention to this." A Resident Council Concern/Complaint form, dated 1/10/23 by V16 (Activities Director), documents "Residents would also like if (R9) was out of the facility because they feel unsafe."

A documented summary of V10's (Ombudsman) notes from the 1/10/23 Resident Council Meeting include the following information: "Other concerns: (R9) is touching and grabbing women in a sexual behavior. (R9) is pinning residents against walls and counters as well. (R6) stated that (R9) has looked up her skirt, grabbed her breast, and rubbed his penis on her many times. It was stated in resident council that (R9) does not have a 1:1 anymore," and "(R13 stated R9) touched my boobs and rubbed his penis on me," and "(R11 stated R9) is getting into people's faces and personal space and touching the way she don't want to be touched."

On 1/26/23 at 4:11 pm, R9 was ambulating throughout the building, into the common areas and up and down hallways. R9 was being followed by V28 (Dietary Manager) who was approximately 15 feet or more behind him watching a video on her cell phone as he ambulated throughout the hallways. R9 eventually returned to his room and V28 sat down in chair outside his room. When asked why R9 needed 1:1 supervision, V28 stated for his "behaviors." When V28 was asked as to what type of behaviors R9 exhibited, V28 stated she did not know.

On 1/24/23 at 3:15 pm, V4 (Social Service) stated R6 told her on 1/05/23 that R9 was "rubbing on her butt, breast and saying inappropriate sexual statements to her, wanting a kiss and telling her

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S9999	Continued From page 11 to drop that a**." According to V4, R6 stated she could hear R9 "wandering the halls at night, all night, going into others' rooms." V4 stated R6 was very upset over the fact that R9 had been on 1:1 supervision in the past for similar behavior but was taken off 1:1 supervision and was "allowed to do this to her." V4 stated she wrote up the statement from R6 on 1/05/23 and then took it to morning meeting with all the Department Heads on 1/06/23 to be discussed. V4 stated V1 (AIT) and V2 (Assistant Administrator in Training) were present in that meeting. V4 stated R9 was eventually put back on 1:1 supervision, but not until another incident occurred a week later. V4 was uncertain of the details or nature of that incident. V4 stated she felt what R9 was doing to R6 was sexual abuse, but R9 "doesn't have the ability to understand that his behavior is sexually inappropriate." On 1/24/23 at 3:45 pm, V16 (Activities Director) stated she typed the 1/10/23 Resident Council Meeting Minutes and then completed a form with each concern on it and delivered those concerns to the appropriate Department Heads. V16 stated V1 was present at the 1/10/23 Resident Council Meeting, as she was invited by the residents due to all the concerns. V16 stated multiple residents brought up R9's behavior in that meeting, complaining that R9 is "very sexual. (R9) will literally come up behind a person, grab their hips, get real close and dance with them." V16 stated residents complained that R9 would "make sexual comments to people as well. They piped in and said (R9) had been overly sexual towards them. They didn't bring up specific times but chimed in when it was brought up." V16 stated she started at the facility in August, and in the last 3 months R9's sexual behavior has become more frequent. V16 stated R9 was taken off and put	S9999		

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S9999	Continued From page 12	S9999		

back on 1:1 supervision multiple times in a month and V16 discussed this with V1 several times, as it was concerning to her. V16 stated, "I've brought this up to (V1) several times, but (R9) still does things. I really don't know if what he is doing is sexual abuse or not. I really can't say. I never received any kind of abuse training when I started in August or since then."

On 1/26/23 at 8:15 am, V10 (Ombudsman) stated she attended the most recent Resident Council Meeting (1/10/23). V10 confirmed that V1 and V2 were present for that meeting. V10 stated during the meeting, R6 and some other female residents complained about R9 being sexually inappropriate. V10 stated R6 verbalized in the Resident Council Meeting R9 "rubbed his penis on her and rubbed her boobs." V10 stated she was in the facility on 1/19/23 and R9 was roaming the hallway unsupervised and groped her buttocks. V10 indicated that each time she has been in the facility recently, on 1/03/23, 1/10/23 and 1/19/23, R9 was not on 1:1 supervision and residents have complained to her that R9 isn't supervised enough. V10 stated she spoke with V1 on 1/19/23 about R9's behaviors and lack of supervision, and V1 told her, "The facility does not want to have (R9) on 1:1 at all times because it is expensive." V10 stated R6 tries to run away from the facility and recently cut her head when she put it through her bedroom wall. V10 stated she talked with R6 about this behavior and R6 stated she did all those things because "staff wouldn't listen to what she had to say or help her."

On 2/04/23 at 11:10 am, V32 (RN) stated R9 had been on 1:1 supervision for his sexual behaviors, but it stopped because the facility didn't have enough staff to provide constant supervision of

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 02/23/2023

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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S9999	Continued From page 13 him. V32 stated she heard that R6 reported R9 touched her inappropriately on 1/05/23, but "nothing was done about it." V32 stated a few days after 1/05/23, R9 went up to R14 and started "humping her from behind, rubbing his crotch on her." V32 stated she texted V1 to tell her about the situation, since R6 had just reported something similar on 1/05/23, but V1 just got upset with her for texting her at night. V32 stated she was concerned because she thought R9 "was to be supervised 1:1 all the time after the last abuse (Illinois Department of Public Health deficiency) written on him, from what I was told." V32 stated she has even witnessed R9 do sexually inappropriate dancing during "Moves and Grooves," which is an activity ran by V16 (Activities Director). V32 stated "It was almost like staff were encouraging this behavior from (R9) and didn't understand it was wrong and inappropriate." V32 stated she has witnessed night shift Unit Aides watching movies on their phones when they are to be providing residents, R9 included, with 1:1 supervision. On 2/01/23 at 5:40 pm, V34 (Unit Aide) stated about two months ago, R9 was "going up to residents and 'air humping' them, rubbing himself on males and females. It was so bad the police had to be called, but the police said they couldn't do anything with him." V34 stated R9 was being supervised 1:1 that day and still acting out towards other residents sexually, because staff couldn't stop him. V34 stated he has provided R9 with 1:1 supervision before and R9 "will not want to stay in his room and will want to walk around the building. He is fast. Some residents get scared of (R9) because he will yell at them. I've been told in the past, from other staff and (R6) that (R9) needs to be watched for doing inappropriate things to her."	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 02/23/2023

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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S9999	Continued From page 14	S9999		

On 1/25/23 at 10:35 a.m., V19 (Certified Nursing Assistant/CNA) stated, "(R9) likes pulling his pants down exposing himself and dancing around inappropriately laughing; it's common behavior. He wanders in and out of resident's rooms."

On 1/25/22 at 10:50 a.m., V25 (Licensed Practical Nurse/LPN) stated, "(R9) is like a vampire; sleeps all day then awake at night and starts acting out. He is very animated. He is sexually aggressive verbally. Last night he was sexually inappropriate with me."

On 1/26/22 at 2:10 p.m., V8 (CNA) stated R9 will say sexually inappropriate statement to residents. V8 stated, "I know he's tried to grab females, like (R6), going up behind her inappropriately. (R6) reported to me that (R9) wouldn't quit following her and tried to grab her. I told her to talk to Social Services, because I know something may have been done previously, but she still complains about it. I didn't report anything to (V1). I would say it was sexual abuse because (R9) is inappropriate with it. (R9) will randomly just get in a mood where he gets sexually inappropriate. I want to say he did have a 1:1, but he is quick (moving). I don't know who determines if he needs a 1:1. He has come off then he will be put back on is because he's been sexual or trying to poop outside."

On 1/26/23 at 4:21 pm, R3 stated R9 has been on and off 1:1 supervision since he was admitted. R3 stated R9 was most recently returned to 1:1 supervision after the January Resident Council Meeting, "when all that stuff was brought up about (R9) being really sexual with the female residents, touching them and rubbing himself against them. But even after that, (R9) will just

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 02/23/2023

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 15	S9999		

roam free some nights. He goes in and out of other resident rooms. I think he looks for food, but who knows what all he's doing in there. I've seen (R9) come up behind the girls and be sexual with them, touching them in places he shouldn't, just out in the open and in front of staff. They don't do anything most of the time. Some of the staff will tell him to stop or distract him away from the girls, but (R9) pretty much does what he wants."

On 2/01/23 at 12:50 pm, R18 stated, "(R9) has grabbed my arm and pulled me in to him, making me sit on his lap. It made me uncomfortable. I didn't like it. Staff were around; it was by the fireplace, but they didn't stop him. I got up on my own after he let me go. This wasn't that long ago, maybe a month."

On 1/25/23 at 10:34 am, R11 stated she did complain at the Resident Council Meeting this month about (R9). R11 stated, "(R9) will get in my face and yell real loud at me, saying all sorts of mean stuff." R11 stated this had been going on for "awhile" and "staff would see it happening and do nothing." R11 then stated, "(R9) has touched me, but I don't want to say where; he scares me."

On 1/30/23 at 10:18 am, R6 was interviewed over the phone, as she was admitted to the hospital. R6 stated R9 "touches my boobs, tries to kiss me, and will come up to me and rub his penis on me through his clothes. (R9) will hold on to me from behind. It makes me feel uncomfortable and this happens almost every single day." R6 stated R9 will call her names, like "N****r, C**t, and B***h" when she pushes him away. R6 stated the problems with R9 started over a year ago, and she has told many staff, including V1 (AIT), V2 (Assistant Administrator in Training) and V4 (Social Services Director). R6 stated, "Staff do

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 02/23/2023

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 16	S9999		

nothing and (R9) is allowed to come down my hall all of the time." R6 stated sometimes R9 "is 1:1 with staff and at other times he's not, especially at night." R6 described how she is afraid to come out of her room, unable to go get ice and eats meals in her room to hide from R9. R6 stated she is "afraid" of R9 and R9 makes her "feel uncomfortable." R6 stated she is coming back to the facility soon and is very worried about what might happen with R9 still in the facility. R6 stated she recently put her head into the wall of her room because she was angry and frustrated with living in the facility. R6 also stated she tried to leave the facility last Sunday, which was why she was in the hospital. When R6 was asked why she tried to leave, she stated she was "angry about everything. Having to live there. (R9) not leaving me alone. Staff not listening to me about (R9) and other things. Staff being mean to me. (R9) follows me around all the time calling me names. Staff don't stop him." When R6 was asked if she feels safe in the facility, she stated "not at all." R6 stated the last time she tried to run away from the facility she was "angry about everything" and stated, "It was not a good day. I had enough of that place." R6 stated she really wanted to kill herself that day, and "just get it over with." R6 stated as she was leaving the building, V6 (CNA) was walking behind her and telling her to "just go ahead and hang myself. So, that's what I was trying to do, get out of there and kill myself." R6 was interviewed again, after returning to the facility, on 2/01/23 at 12:48 pm. At that time, R6 stated, "Just last night (R9) was following me around, he called me a "Retarded B***h" while staff were with him, following him as he walked around."

On 1/31/23 at 1:45 pm, V30 (Police Officer) stated he said he has responded to the facility

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 02/23/2023

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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S9999	Continued From page 17 several times over R6's threats of suicide. V30 stated R6 always tells him that she can't stand to live there anymore because the staff don't listen to her or help her. On 1/25/23 at 12:59 PM, V1 stated R6 came to her with concerns that R9 was "getting too close to her." V1 could not recall what day that occurred, but indicated it was recent, "within the month." V1 stated, "We had actually been trying to wean (R9) off 1:1." V1 stated she had no knowledge of the 1/05/23 grievance completed by V4; however, V1 acknowledged that R9's Resident Monitoring Logs document he was placed back on 1:1 supervision at 12:00 am on 1/06/23. V1 stated she did not know what behavior had occurred for R9 to be returned to a higher level of supervision, nor could she find documentation as to why. V2 was in the office during this interview and denied knowledge of the grievance as well. V1 and V2 denied V4 bringing to the attention of Management that R6 had complaints of R9 touching her sexually during the 1/06/23 morning management meeting. V1 stated, "Had I known, I would have reported an allegation of sexual abuse." V1 stated the only thing R6 told her was that "(R9) was getting in her personal space, but not that (R9) had physically touched her." V1 stated she did not have any documented evidence of this conversation with R6, or any subsequent actions taken. V1 explained, "(R9) is able to be taken off and on 1:1 based on his behavior. They will review his behaviors and if they increase, or if he is not able to be redirected, it can be reimplemented. That's in his Plan of Care." V1 confirmed that she was in attendance for the Resident Council meeting on 1/10/23. V1 stated she did not interview the four female residents that spoke out about R9's behavior. V1 stated, "I recall (R6) speaking out	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 02/23/2023

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 18	S9999		

Continued From page 18

against (R9) and (R10) as well. I do not remember the other two residents having specific concerns with (R9). I can't tell you my exact immediate follow up. I did not interview any residents that had concerns. At some point, I had a conversation with (R6 about R9), but I do not know when and did not document the details."

On 2/02/23 at 1:59 pm, a follow up interview was conducted with V4 (Social Service Director) regarding R6's allegation against R9 and the 1/06/23 Morning Meeting with Management. V4 stated it was clearly discussed in that meeting that R9 had increasing behaviors, going in and out of resident rooms at night, and what R6 reported on 1/05/23. V4 stated Management suggested at that R9 go on 1:1 supervision or they find placement for him elsewhere. V4 stated they discussed R9 being placed back on 1:1 supervision "so it didn't escalate to a reportable incident. If (V1 and V2) stated they didn't know this, they are lying."

Upon entering the facility on 1/24/23 at 9:10 am, V1 (AIT) was asked for all the facility's Abuse Allegations investigated and reported to the Illinois Department of Public Health in the last 90 days. V1 provided three separate investigations, none of which involved R9, and indicated those were the only Abuse Allegation Investigations she had.

On 1/30/23 at 9:17 am, V1 stated in a follow up interview she has still not initiated any kind of formal investigation into the sexual abuse allegations reported to her last week involving R6 and R9. V1 stated she was completely unaware of R9's "sexually tendencies" until the survey team brought it to her attention last week. V1 stated V31 (Administrator) is still unaware of the

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 02/23/2023

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 19	S9999		

allegations of sexual abuse by R9.

A.2. An official court document, dated 4/10/2017 documents V30 (R6's Mother) and V37 (R6's Father) as being appointed "Guardians of the Estate & Person of (R6), a disabled adult, and are authorized to have, under direction of the Court, the care, management, and investment of the ward's estate and the custody of the ward, and to do all acts required by them by law." A Resident Profile Face Sheet documents R6 was admitted to the facility on 5/24/19. A Subpart S Eligibility Screening, dated 5/13/22, documents under Section B that R6 has the diagnoses of Schizo-affective Disorder and Bipolar Disorder, and under "Section E - (checked for yes) Are impairments in these areas primarily due to the resident's serious mental illness listed in Section B. (Checked for yes) Resident's impairment cannot be primarily due to any of the following (Check box if impairment is due to diagnosis listed):" with "Mental Retardation" circled. Physician's Orders, dated 1/01/23, document R6 has the current diagnoses of Anxiety, Schizoaffective Disorder, Intellectual Disability, and Chronic Post Traumatic Stress Disorder. R6's Current Plan of Care, which has not been updated since 9/09/22, documents R6 has Impaired Communication (expressive), ambulates independently and "has risk factors that require monitoring and intervention to reduce potential for self-injury." A Hospital History and Physical, dated 1/23/23, documents R6 as alert and oriented, but with limited judgement and insight, and below average intelligence. Behavior Tracking for October, November and December 2022 and January 2023 documents R6 is being monitored for the following targeted behaviors: Self Harm/Suicidal Ideations, Repetitive Verbalizations, Physical Aggression Towards

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 02/23/2023

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 20 Others, Intrusive Thoughts, Verbalized Hallucinations/Delusions, Exit Seeking, Depression, Self-Isolation, and Verbal Aggression Towards Others. Nursing Notes, dated 10/22/22, document "(R6) got upset because she was asked to leave boyfriend's room and move down to lobby. She went down D Hall to another resident room. She was redirected to leave the hall because of COVID. (R6) got agitated and walked out of the facility through D Hall. Resident was not easily redirected. Walked down to the graveyard, took off all her clothing and laid naked in (a) field. Stated 'I want to die.' The cops were informed. Effort to get (R6) up not successful. Rescue team informed, got her up and was taken to (hospital)." Nursing Notes, dated 12/18/22, document "(R6) found in male patient's bed. They were wearing clothes. (R6) said she thought it was ok, as long as they don't have sex. Encouraged (R6) not to go in male resident room. She was easily redirected." Physician's Orders, dated 2/01/23, document R15 has the current diagnoses of Schizoaffective Disorder, Bipolar type, Catatonic Schizophrenia, and Psychosis. A Surrogate for Decision Making form, dated 12/29/22, documents V36 (R15's Sister) is R15's legal Surrogate Decision Maker. A Social Service Progress Note, dated 12/29/22, documents "(R15) has a girlfriend (R6) and family does not want them having sexual relations." R6 and R15's medical record contain no documented evidence of a plan developed or implemented to ensure R6 and R15 were not engaging in sexual activities with each other. On 1/31/23 at 1:05 pm, V10 (Ombudsman) stated V30 (R6's Mother) contacted her today, very upset and concerned about R6 being in a sexual	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 02/23/2023

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 21	S9999		

relationship with a male resident in the facility. V10 stated V30 discussed this with the Social Services Department in December, but the facility was not doing anything to stop R6 from having sexual intercourse with this resident. V30 stated the concern is that R6 does not have the mental capacity to consent to a sexual relationship with someone.

On 1/31/23 at 2:44 pm, V30 stated V30 found out this summer that R6 was in a "relationship" with R15. V30 stated she was concerned, because R15 is twice R6's age, but she was just calling R15 her "boyfriend." V30 stated nursing staff in the facility started telling her she should "press her daughter for more information" about her relationship with R15. V30 stated it was as if the staff knew R6 needed to tell her what was really going on with her and R15. V30 stated, "Around the beginning of November, (R6) told me she had been caught having sex with this man (R15), in his room and her room, multiple times," and "I'm concerned because I'm (R6's) State appointed guardian and (R6) has the mental capacity of a 10-13 year old. I spoke to (V1) immediately after I found out, and (V1) told me (R6) was a consenting adult and there was nothing they could do about her having sex with this man, who is twice her age."

On 2/02/23 at 1:30 pm, V30 stated she reviewed her phone records and she spoke with V1 on 11/08/22 about R6 and R15 having sex. V30 stated V1 told her R6's BIMS (Brief Interview for Mental Status) was too high, and they were able to consent to a sexual relationship. V30 stated she told V1 that she did not agree, as "(R6) has the mentality of a teenage girl." V30 went on to say, "This is my baby (R6) and I feel like (R15) is a predator."

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 02/23/2023

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 22 On 2/01/23 at 12:52 pm, R15 stated he is in a sexual relationship with R6. R15 stated they have sex in his room or hers, or "sometimes on the couch." R15 stated they had been having sex "for a while now." On 2/01/23 at 1:17 pm, R6 stated she has sex with R15. R6 stated, "(R15) is my boyfriend and we are going to get married." R6 was asked where she has sex with R15, and she stated, "Wherever" and "Oh we've been caught by people." R6 was asked if she had sex with R15 in his room or hers, and she stated both. R6 was asked what happens when they get caught and R6 stated, "They just tell us not to do it again. My Mom knows. I told her. I told her we want to get married." On 2/2/23 at 10:00 a.m., R6 stated, "We (R6 and R15) have sex. We've tried to have a baby three or four times to get out of here and move to Chicago, but I guess this thing is working (pointing to her birth control implant in her left upper arm)." On 2/02/23 at 1:59 pm, V4 (Social Services) stated she talked to both R6 and R15's families regarding their sexual relationship in December, but "(R6 and R15) had a high enough BIMS, so they could not stop them." V4 stated, "(V1) was fully aware (of their sexual relationship); she has talked to (R6 and R15's) family regarding this." V4 stated they did discuss developing a care plan with individualized interventions to keep R6 and R15 from having sexual relations, but that never transpired. V4 stated R6 openly talked about being sexual with R15. V4 stated, "It was common knowledge amongst staff, that they would have sex; it would trickle down to residents	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 02/23/2023

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 23	S9999		

and then to Social Services."

On 2/01/23 at 2:33 pm, V14 (Social Service) stated R6 does think R15 is her boyfriend. V14 stated she has heard from multiple staff and residents that R6 and R15 are in a sexual relationship. V14 stated, "The first time I heard about them having sex, (R6) was in the hospital. It was a couple of months ago. Since (R6) was in the hospital, it was after the fact, and I did not report it to (V1)." V14 stated there was a recent Care Plan meeting with R6's parents, V4 and V15. V14 stated, "The main topic of that meeting was (R6's) sexual relationship with (R15)." V14 stated, "(R6) is cognitively there, but she does have a State appointed guardian. I feel she (R6) is able to consent to a sexual relationship."

On 2/04/23 at 11:20 am, V32 (RN) stated R6 and R15 got caught having sex in R15's room; staff were told to not let her in his room after that. V32 stated this happened about two months ago, along with R6 telling staff she thought she was pregnant, but nothing was ever done to prevent them from having a sexual relationship. V32 stated staff will catch R6 and R15 in the common area "doing sexual things to each other" and staff would tell them to stop but not separate them and "they would go right back at it."

On 2/2/23 at 8:33 am, V36 (R15's Healthcare Surrogate) stated she became aware of R15 and R6's "boyfriend/girlfriend" relationship 6-7 months ago. V36 stated she could see that the relationship was continuing, and she discussed this with Social Service Staff at the December 2022 Care Plan meeting. V36 stated she told staff at that meeting she did not want R15 engaging in a sexual relationship with R6 "for many obvious reasons, including pregnancy." V36 stated, "I was

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 02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 24	S9999		

under the impression staff would supervise the residents enough to ensure they were not having sex."

On 2/01/23 at 3:55 pm, V1 (AIT) stated, "All I know regarding (R15 and R6) is that (R6) told her mom that they are married," and "I have never been told they were in a sexual relationship." V1 stated she would expect staff to tell her if they had knowledge of them being in a sexual relationship. V1 stated she personally does not feel R6 has the mental capacity to consent to a sexual relationship.

A.3. Resident Council Meeting minutes, dated 1/10/23 document the following concerns: "LPN (is) stealing narcotics," "CNAs yelling at residents is not okay and needs to stop," and "(CNAs) retaliating with residents when they have an issue with things."

A Resident Council Concern Form, completed by V16 (Activities Director) on 1/10/23, documents "Department: Administration," under "Concern/Complaint" it states in the notes section, "CNAs and nurses are retaliating when they (residents) bring issues to them that staff does not agree with," and "(R2) also brought up LPNs stealing narcotics." A Resident Council Concern Form, completed by V16 (Activities Director) on 1/18/23, documents "Department: CNAs," under "Concern/Complaint: Residents believe that the CNAs yelling at residents is not okay," and "They are also concerned that the CNAs are retaliating when the residents bring up issues to them that they do not agree with." A Resident Council Concern Form, completed by V16 (Activities Director) on 1/10/23, documents "Department: Nursing," under "Concern/Complaint: Certain Nurses are

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 02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 25	S9999		

retaliating against residents who give them issues."

A documented summary of V10's (Ombudsman) notes from the 1/10/23 Resident Council Meeting include the following information: "(Nursing Staff) ignore residents when residents need help. One resident stated the less cognitive a resident is the worse it is for them," "Residents being forced to stay in their rooms or go to their rooms," "It was stated that when (R3) had a fainting episode staff makes fun of him because the staff think he is faking it (V11/RN)(is the main one)," "(R3 stated) backlash is horrible from staff. Nurses get in your face and saying f**k you, you're going to your room. Resident is staying in his room due to being uncomfortable."

On 1/26/23 at 8:15 am, V10 (Ombudsman) stated she was present for the 1/10/23 Resident Council Meeting and several residents attended. V10 stated V1 (AIT) and V2 (Assistant Administrator in Training) were present for the entire meeting. V10 stated R2, who is the Resident Council Vice President, was voicing most of the concerns, and R2 even had all his concerns typed up, giving everyone a copy. V10 stated other residents were agreeing with R2's issues brought forth. V10 stated several resident concerns were abusive in nature. V10 stated R2 verbalized he has witnessed nursing staff, specifically V3 (Resident Care Coordinator), take resident medications home with her after she dispenses medication from the pill sleeve. V10 stated multiple residents complained of staff retaliating when they complain about something, staff will be mean to them, make fun of residents, and yell at them. V10 stated she has discussed abuse concerns with V1 before, but "she does not act on them." At that time, V10 provided a copy of the typed

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 02/23/2023

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 26	S9999		

concerns from R2 that was given to everyone in attendance at the 1/10/23 Resident Council Meeting.

R2's documented Grievance List from 1/10/23, provided by V10, documents the following statements: "(Licensed Practical Nurse, name withheld) pulls meds, while pulling meds, when she grabs meds out of lock box (for narcotics), she pops all meds into dispensing cup, except the narcotic, it gets popped onto the top of (the medication) cart and slipped into her pocket."

On 1/24/23 at 3:45 pm, V16 (Activities Director) was interviewed regarding all the abuse concerns documented from the Resident Council Meeting on 1/10/23. V16 confirmed that V1 and V2 were present for the meeting that day. V16 stated that staff retaliation against residents was mentioned by R2, but "he didn't expand on it" so she was unaware of what R2 meant specifically. V16 stated it was discussed during the meeting that residents have observed nursing staff "popped the narcotic pill out, put it to the side of the medication cart, then slide it into her pocket." V16 recalled R2 stating that if residents do something that the CNAs don't like, they will "raise their voices" at them. V16 went on to say that she documented all the resident concerns and gave specific concern forms to each Department Head, as well as a copy of the Resident Council Meeting Minutes to V1 (AIT).

On 1/25/23 at 12:59 pm, V1 (AIT) confirmed that she was present for the 1/10/23 Resident Council Meeting, and she had received a copy of the 1/10/23 Resident Council Meeting notes. V1 stated, "I still want to go through and talk to residents. When I get complaints, I don't always jump." V1 stated, "My approach to the wrong

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 02/23/2023

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 27 medications being given and narcs (narcotics) being stolen was to wait and see how med (medication) pass was going. My thought process is it not over. I'm waiting to sneak up and see what I catch." V1 stated she did complete a Narcotic Count at the medication carts, which was fine. V1 stated she at some point asked V3 (LPN/Resident Care Coordinator) if anything had been reported regarding missing narcotics, and the answer was no. V1 stated she did not conduct a full investigation into the misappropriation of resident's narcotics, nor did she report the allegation to the State Agency. V1 stated she just started getting copies of the Resident Council Meeting minutes and she received the copy from the (1/10/23) meeting minutes last week. V1 stated she did read the minutes when she received them and acknowledged "There were several serious concerns brought up at the meeting." V1 stated she did not interview any residents that had specific concerns, but she did have a conversation with R6. V1 stated she could not recall any specifics regarding the allegation of CNAs "yelling at residents," but "I decided to do a broad in-service regarding bedside manner and customer service that day, as it was a scheduled in-service day." V1 did admit that the allegations that came from the Resident Council Meeting "could lead to an abusive situation." V1 stated she did ask R16 in that moment during the Resident Council Meeting what staff were yelling at residents and then R16 denied anything occurred. V1 stated she did not interview in private or probe further, with any other residents regarding the concerns. V1 stated, "I didn't view the complaints warranted interviewing specific residents in private to determine what CNAs are yelling at residents and what they are yelling at them for." V1 stated she did not interview any staff regarding other staff's behavior. When V1	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 02/23/2023

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 28	S9999		

was questioned about the statement made by R2 that staff are retaliating against them when they complain, V1 stated she "talked to my Department Heads and instructed them to do 'Angel Rounds,' inquiring as to if residents have concerns about retaliation." V1 was unable to provide any documentation related to the information gathered during 'Angle Rounds.' V1 stated, she did not recall the word "retaliation" being used in the Resident Council Meeting but concluded "retaliation is concerning."

A.4. On 1/26/23 at 8:15 am, V10 (Ombudsman) stated 1/19/23, she informed V1 that R3 had reported to her V27 (LPN) was hitting him in the leg when she passes medication and that V3 (LPN/Resident Care Coordinator) had yelled at R3 a few days prior. V10 said she specifically told V1 that R3 reported to her V3 yelled at him to "Shut the f**k up" and threatened to call the police on him. V10 stated V1 informed her that she had already spoken to V3 about the situation and "that was not what had happened." V10 stated she was concerned that V1 did not report or investigate this allegation of abuse.

On 1/24/23, at 10:33 am, R3 stated on 1/16/23 he had been waiting for his noon medications at the Nurses' Station, for about 20 minutes. R3 stated V3 started walking away with the medication cart, headed to the Dining Room. R3 stated he spoke up and told R3 he didn't get his noon medication. R3 stated V3 told him that he would have to follow her to the dining room if he wanted his medicine. R3 stated he did state, "Are you kidding me?" as he had been waiting for 20 minutes and prefers not to take all his medication in the dining room. R3 stated another resident, R16, was waiting for her medicine at the nurses' station with him and had to follow V3 into the dining room.

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 02/23/2023

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 29	S9999		

According to R3, once he and R16 entered the dining room and waited by the medication cart, V3 informed R16 she would now have to wait again for V3 to return to the nurses' station to receive her medication, because not all her medicine was in the medication cart, and she needed to access the medication room. R3 stated he did speak up and told V3 this wouldn't have happened had she just given them their medicine when they were waiting at the nurses' station. According to R3, at that point V3 "leaned across the (medication) cart, towards me, and started yelling at me to 'shut the f**k up and leave' and when I didn't, she said 'get the f**k out or I'm calling the police.'" R3 stated he immediately told V1, who was in her office just outside of the dining room, what V3 yelled at him. R3 stated multiple other CNAs were present in the dining room when it happened and there are cameras in the area. R3 stated V3 stayed working in the facility the remainder of the day and he asked for a different nurse to give him is medication. R3 stated he also reported to V10 that V27 will wake him up by "smacking" his leg to give him his medication. R3 stated he gave V10 permission to report that to V1, which she did that same day. R3 stated, "Nothing was done about (V27) though. (V1) never even asked me about it."

On 1/24/23 at 12:10 pm, V1 stated, about one week ago, V3 came to her asking for help with R3, because of his behaviors. Immediately after that, R3 came to her and stated V3 had yelled at him when he was trying to get his medications that day during lunch. V1 stated R3 and V3's stories did coincide, apart from V3 denying yelling at R3. V1 stated she was in her office at the time this incident occurred, and her door was cracked, but she did not hear any yelling. V1 stated she did hear R3's "voice elevated, but he has a loud

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 02/23/2023

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 30 voice," and does not know what he said. V1 stated R3 told her that V3 threatened to call the police on him if he didn't step away from her medication cart and that she yelled at him to 'get the f**k out of my face.' V1 stated R3 admitted to her that he "could have provoked" V3. V10 stated V3 admitted that she "firmly told (R3) to step away" from her but denied cursing at him or yelling. V1 stated she interviewed three CNAs that were in the area at the time of the alleged incident, along with V2 (Assistant Administrator in Training), who denied hearing V3 yell at R3. V1 stated she did not interview any residents that were in the dining room at that time and V3 worked the remainder of the day without being suspended. V1 stated she would consider the statement "get the f**k out of my face" towards a resident abusive but considered the allegation at the time a "grievance" and did not report the incident or formally investigate it. V1 admitted there is surveillance footage she could have looked at in the dining room but did not. V1 confirmed that a couple of days later, the Ombudsman did speak to her about R3's allegations that V3 had yelled at him and stating "get the f**k out of my face" and his concerns with V27. V1 indicated she did not have any documented evidence of interviewing V3, R3 or the CNAs that were present in the dining room at the time of the alleged incident. On 1/24/23, R3's medical record contained no documentation related to his allegations of abuse. On 1/25/23 at 12:59 pm, when V1 was asked if she had reviewed the video footage from R3's 1/16/23 allegation, V1 stated the video for the incident with R3 and V3 may not be available at this point based on what her capabilities are with the video equipment.	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 02/23/2023

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 31 On 1/30/23 at 9:17 am, V1 stated she had still not initiated a formal investigation into R3's abuse allegations. On 2/04/23 at 11:10 am, V32 (RN) stated she witnessed V3 yell at R3 "get the f**k out of my face." V32 stated R3 was not yelling at V3 but was upset over his medication. V32 stated V1 never interviewed her regarding the incident. A.5. R1's TAR (Treatment Administration Record) dated 1/23, documents that R1 requires daily skin checks. The TAR has no documentation of these daily checks being completed on 1/13/23-1/16/23. R1's Hospitalist Admission History and Physical, dated 1/17/23, documents, "R1 with severe schizophrenia, tardive dyskinesia, seizure disorder brought in from facility with complaints of lethargy and worsening tremors. She has not been taking her medication in the facility. R1 is lethargic, barely responsive. Physical exam: Skin, hair, nails: Ecchymoses in various stages of healing on bilateral legs and inner thighs." R1's Hospital History and Physical, dated 1/17/23, documents, "Assessment/Plan: Multiple bruises especially lower extremities, present on admission." On 1/24/22 at 2:45 p.m., V13 (Hospital RN) stated, "I got concerned when I saw (R1's) bruising on her inner thighs that looked like fingerprints. The bruising was in the shape and pattern of fingers. There are pictures of the bruising in her chart that we took. She also had bruising on the outside of both of her hips in the same spot and in a circle like the size of a dollar coin. These bruises were not brand-new bruises;	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 02/23/2023

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 32	S9999		

some of it was starting to fade out and had some yellow coloring. The facility was notified of the bruising by our staff the day she was admitted. I did not call the facility, but someone else did and the facility told them that they were not aware of any bruising on (R1). Facility stated, 'When (R1) is in her room by herself she rests peacefully. Then, once we enter her room she starts shaking, her lips quiver, and she acts anxious and scared. When I went to change her (incontinence) brief she instantly squeezes her legs together tightly and gets nervous. It's like she's scared something is going to happen when we care for her.'"

On 1/25/23 at 12:59 pm, V1 (AIT) stated, "I'm unaware that the hospital reported any bruising injury to my staff for (R1)." State surveyor reported R1's bruising at this time.

On 1/26/22 at 12:00 p.m., V1 retrieved R1's hospital records on V1's computer. V1 received the photos of R1's bruising to R1's bilateral inner thighs. R1's Hospital Records document a photo of R1's left and right inner thighs. R1's left inner thigh has bruising in the shape of two lines, one being the length of half of R1's thigh. The bruising is located directly in the middle of R1's left thigh. R1's right inner thigh bruising is located from the middle of her thigh to the back of her knee area. R1 has a large circular bruise, and a bruise in a linear shape as well.

On 1/26/22 at 1:30pm, V1 stated, "I've just started an investigation on (R1's) bruising. I've talked to staff, and they have all stated that R1 has had bruising on her legs and thighs before from putting herself on the floor and running into things. When I spoke with staff I didn't probe to ask specifically about her inner thighs. I asked a general question of where her bruising is located.

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 02/23/2023

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 33	S9999		

(V8/CNA) and (V17/CNA) were interviewed, and both stated that (R1) had bruising on her inner thighs. I don't suspect sexual abuse whatsoever."

On 1/26/23 at 2pm, V17 (CNA) stated, "I've seen bruising on (R1's) legs and arms. I've never seen any bruising on her inner thighs." V17 was showed the pictures from the hospital. V17 gasped and said, "Oh no. I have never seen any bruising like that. She wouldn't have bruising like that from the stuff she does that she gets bruises from."

On 1/26/22 at 2:10 p.m., V8 (CNA) stated, "I've seen bruising on R1's legs and arms before, especially her shins. She puts herself on the floor and falls a lot." V8 was shown the pictures of R1's bruising. With a surprised look on her face, V8 stated, "No she's never had bruising like that! I've never seen bruising on her inner thighs before."

A report to the State Agency, dated 2/3/23, documents, "Original Allegation: State Surveyors reported to V1 that hospital reported to the State Agency bruising of unknown origin to lower extremities of resident signifying sexual abuse. Account: Police department, physician, and responsible party were immediately notified of allegation. Staff were interviewed of noted bruising on resident. Staff stated that bruising has been noted due to resident repeatedly putting self on floor and self-harming by hitting legs with bathroom door during moments of agitation. Determination/Conclusion: It is determined that the allegation of sexual abuse is unfounded. It is determined that the resident commits self-harm during episodes of agitation which is care planned."

A.6. On 1/24/23 at 11:50 a.m., R5 was alert but

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 02/23/2023

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 34	S9999		

nonverbal sitting up on the side of her bed. R5 had a purple and yellow bruise with swelling to the outer corner of R5's right eye.

R5's MDS (Minimum Data Set), dated 11/20/22, documents R5's BIMs (Brief Interview for Mental Status) had a score of 99 (severely impaired cognition).

On 1/24/23 at 2:20 p.m., V17 (CNA) stated, "I saw (R5's) bruise on her eye this morning and asked what happened. (V8/CNA) was sitting there with (R5) and said (R5) has had the bruise for a few days." V11 (Registered Nurse/RN) was present as well and stated, "(R5) has a bruise on her eye? I didn't even notice she had a bruise, and I gave her medicine today."

On 1/24/22 at 4:30 p.m., V11 (RN) stated, "Yeah I guess (R5) does have a bruise on her eye. Supposedly, (V8) knew for a few days that (R5) had the bruise. I worked the weekend and (V8) never told me about it. I haven't done any kind of report on it. I reported it to (V1/AIT) today."

On 1/26/23 at 2:10 p.m., V8 (CNA) stated, "Monday night (1/23/23) at dinner time was the first time I saw (R5's) bruise on her eye. I heard (R5) had ran into a wall or something like that. I didn't talk to anyone because I assumed it was already documented as a fall."

On 1/25/23 at 12:59 pm, V1 stated, "Staff did report to me just this morning that (R5) does have a bruise to her eye. They (Nursing) are thinking the injury is from her head resting on her headboard and she moves around. They (Nursing) are going to try to come up with an intervention. I'm just going with what the nurse told me and going with that. I have not talked to

Illinois Department of Public Health

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 02/23/2023

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 35	S9999		

any other staff regarding the injury and was not going to do an investigation."

On 1/26/22 at 12:00 p.m., V1 confirmed she had not started any abuse investigations for R1 or R5 at this time.

The CMS-672 (Resident Census and Conditions of Residents), dated 1/24/23 and signed by V1 (AIT), documents 116 residents currently live in the facility.

B. The facility's Administrator Job description summary documents, "The Administrator is responsible for managing, planning, organizing, staffing, directing, coordinating, reporting, budgeting, and the physical management of the facility, residents, and equipment in a way that the purpose of the facility shall be maintained in accordance with all establish practices, policies, laws, and applicable state regulations. The Administrator will manage and conduct the business of the facility in a manner that protects the facility license and certification at all times. The major goal of the Administrator is to provide an atmosphere, in which residents may achieve their highest physical, mental, and social well-being." The job description summary further documents "Responsibilities: 1. Operate a facility in compliance with all federal and state, rules, and regulations; 2. Operate the facility in accordance with establish policies and procedures; 3. Assist in developing and establishing a budget, and managing within it; 4. Appoint a Director of nursing and other department heads; 5. Supervise department heads; 6. Assure, proper facility and department operation through the implementation of the specified quality assurance program."

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 02/23/2023

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 36 A second Administrator Job description provided by the facility documents "Job Summary: The Administrator is responsible for directing day-to-day functions of the facility in accordance with current federal, state, and local standards, guidelines and regulations that govern long-term care facilities to ensure that appropriate care is provided to the residents in the facility. The administrator is responsible for delegating the administrative authority, responsibility necessary for carrying out the assigned duties. Job Relationships: works effectively and maintains a cooperative, working relationship with members of the regional team, Department heads, government agencies, personnel, visitors, family members, staff, and residents." The Administrator's Job description, further documents under "Resident rights: 1. Maintain confidentiality of all resident information. 2. Ensure that the residence rights to fair and equitable treatment, self-determination, individuality, privacy, property, and civil rights, including the right to wage complaints are well established and maintained at all times. 3. Resident complaints and grievances and make written reports of actions taken. 4. Review and respond to resident/family council concerns as needed." During the last 12 months, the facility has been cited by the State Agency on 2/10/22 and 10/30/22 for lack of effective Administrative leadership. Upon entering the facility on 1/24/23 at 9:15 am, V1 (AIT) introduced V2 as her Assistant Administrator in Training and V3 (LPN/Resident Care Coordinator) as her "Acting DON (Director of Nursing)." V1 indicated this was the facility's current Administrative Staff. V31's (Vice President	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 02/23/2023

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 37	S9999		

Continued From page 37

of Business Development and Strategy/Regional Director of Operations) Nursing Home Administrator's license is hanging on the wall of the facility.

On 1/25/23 at 11:25 am, V1 stated she started as the facility's Administrator in Training under V31's (Vice President of Business Development and Strategy/Regional Director of Operations) Administrator's License on 8/22/22. V1 stated she stated she has the paperwork to apply for her Temporary Administrator License, but that documentation has not been submitted at of this time. V1 stated her testing date to become a Licensed Nursing Home Administrator is currently unknown. On 2/09/23 at 3:56 pm, V1 confirmed that V43 was the previous AIT (not a licensed) over the building, and he held that position from 2/16/21 - 7/15/22.

According to record review and interviews, Administration failed to effectively act upon the following events regarding quality of care, quality of life and resident abuse:

1. Administration failed ensure all staff received necessary education and training. The following staff stated they had not received education on the Abuse Prevention Program since they began employment at the facility: V16 (Activities Director), V4 (Social Services), V25 (LPN), V21 (Unit Aide), V9 (Unit Aide), V18 (CNA), V34 (Unit Aide), V5 (CNA), V33 (CNA), and V23 (Housekeeper). Additionally, V1 confirmed the facility has not provided any education or training for new staff on managing residents with behavioral health needs. This includes: V2 (Assistant Administrator in Training), V3 (Resident Care Coordinator/LPN), V11 (LPN), V51 (LPN), V52 (Registered Nurse), V53

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 02/23/2023

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 38	S9999		

(Registered Nurse), V7 (Registered Nurse), V54, V63, V33, V64, V65, V19 (all CNAs), V34, V55, V9, V35, V56, V57, V58 (all Unit Aides), V59 (Transportation Aide), V15 (Social Service), V14, (Social Service), V60 (Activities Aide) and V61 (Activities Aide).

2. Administration failed to acknowledge, immediately report, and investigate allegations of verbal abuse, sexual abuse, and misappropriation, brought forth by residents of the facility during a Resident Council Meeting (1/10/23) in which V1 and V2 were present for.

3. Administration failed to recognize that R9 was to be on 1:1 supervision when out of his room, per his Plan of Care, due to a history of sexually inappropriate behavior towards others. This failure allowed R9 to have unsupervised access to female residents. R6 reported on 1/05/23, R9 had touched her sexually. R6, R11 and R13 reported on 1/10/23, R9 had touched them in a sexually inappropriate manner.

4. Administration failed to respond to numerous grievances and concerns voiced by residents during Resident Council (1/10/2023), affecting the quality of care and quality of life of those living in the facility.

5. Administration failed to recognize that R6, who has a State appointed Guardian, lacked the mental capacity to consent to known ongoing sexual relationship with R15.

6. On 1/25/23 and 1/26/23, the State Surveyors discussed with V1 and V2 the following concerns regarding abuse within the facility: a.) R6 reported to V4 on 1/05/23 that R9 was touching her sexually. b.) R6, R11 and R13 reported in the

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 02/23/2023

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 39	S9999		

January 10, 2023, Resident Council Meeting that R9 had touched them sexually, which was confirmed by V10 (Ombudsman). c.) R3 reported to V1, on 1/16/23, verbal abuse by V3. V10 reported R3's same allegation of abuse to V1 again, on 1/19/23, along with an allegation of physical abuse by V27 (LPN). d.) R1 was found to have suspicious inner thigh bruising of unknown origin when admitted to the hospital on 1/17/23, which was reported to the facility by hospital staff. e.) On 1/24/23, R5 had visible eye bruising of unknown origin, reportedly present for 2-3 days. At the time these concerns were originally discussed with V1 and V2, they had not been investigated or reported to the State Agency per the facility's Abuse Prevention Program. Upon returning to the facility on 1/30/23, V1 had yet to implement their Abuse Prevention Program regarding these allegations by initiating abuse investigations and suspending staff suspected of abuse.

7. Administration failed to ensure that R20, who is nonverbal and depends on enteral nutrition, received gastrostomy tube (g-tube) feedings for adequate nutritional intake and implement dietician recommendations to prevent significant weight loss. R20 went nine days without receiving any type of nutritional intake causing her emotional/psychological distress as well as pain related to hunger pains. R20 has also lost 20 lbs (11.4% weight loss) since R20 was admitted on 8/6/22 (five months).

On 1/26/23 at 8:15 am, V10 (Ombudsman) stated, "I'm in the building frequently, not as often as I'd like. At least 1-2 times per week. I come in and (V1's) door is always closed. If I go to (V1) with concerns she never acts on them. I've gone to her with abuse concerns that she doesn't look

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 02/23/2023

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 40	S9999		

into." V10 went on to explain about an allegation of verbal and physical abuse she received from R3 on 1/19/23, that she spoke to V1 about that day. V10 stated she informed V1 that R3 told her V27 (LPN) would hit him in the leg when she passes his medication, and that V3 verbally abused him a few days prior. V10 stated V1 was not concerned with the allegations made and indicated that she had already discussed the situation with V27 and V3's behavior towards R3; however, V10 stated, "I've discussed abuse concerns with (V1 before), but she doesn't act on them like she should. I'm concerned it wasn't reported or investigated as it should have been." V10 stated residents complain about the way V3 and V8 (CNA) speak to them, and she stated she has "witnessed (V8) blow off medical concerns." V10 stated she was present for the 1/10/23 Resident Council Meeting, and V1 and V2 were in attendance, as they had been invited due to numerous resident concerns. V10 stated R2 (Resident Council Vice President) was voicing most of the concerns and other residents were agreeing with him. V10 stated some of the allegations made during the meeting were abusive in nature. V10 stated it was alleged that (V3) would take resident medications home with her. V10 stated R16 complained about staff not administering her pain medications. V10 stated residents complained of staff retaliating when they complain about something, "like staff will be mean to them, make fun of residents, and yell at them." During the meeting, V10 stated she heard concerns about residents being yelled at by CNAs, nursing staff not doing their medication passes, giving medications late, and doubling up on medication passes. V10 stated, "As soon as the State cleared the facility in November from their Annual Survey, everything changed back to how it previously was. When the facility was trying

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 02/23/2023

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 41	S9999		

to get back into compliance, residents were happier, and Administration was responsive to my concerns. Residents felt like they could go to Administration at that time. But, since November, things have greatly changed. I will bring concerns to (V1), who acts like she cares but never acts on my issues. (V1) stands up for her employees, not the residents."

On 2/04/23 at 11:10 am, V32 (Registered Nurse) stated she has been working as an Agency Nurse at the facility for several months now. V32 stated, "Management is poor, and nothing gets done." V32 stated V1 will remove documentation from resident records and tell staff not to chart resident incidents, altercations, or elopements. V32 stated she had V1 tell her just last month not to document that R21 had eloped from the facility and had to be brought back by a member of the community that found her. V32 stated R6 and R15 have been caught having sex in their rooms and staff have been instructed by V1 to not let R6 in R15's room. V32 stated R9 has been taken off 1:1 monitoring for inappropriate sexual behaviors, because the facility didn't have the staff to constantly monitor him. V32 stated this even happened after "State cited us for abuse (involving) R9 in 2022." V32 stated everyone, including V1, was aware that R6 had alleged sexual abuse by R9 on 1/05/23. V32 stated she texted V1 a few days after R6's allegation (1/05/23) was made, because R9 was being sexually inappropriate with R14, and V1 got upset with her for notifying her of the situation. V32 stated she has witnessed V3 yell at R3. V32 stated narcotics were reported missing about two months ago, but it was not investigated as diversion. V32 stated V3 will "prep" her medication prior to her medication pass, by putting the resident's pills in a cup so V32 can just

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 02/23/2023

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 42	S9999		

hand them out to the resident. V32 stated she knows this is not proper practice, but it is how the medication is routinely handled. V32 stated she has noticed at times resident's that are to be receiving narcotics, the narcotic is not always in the cup prepped by V3. V32 stated, "I have caught staff sleeping at night on third shift. I took pictures and sent them to (V1), but nothing happened to the staff." V32 indicated she has witnessed staff that are to be providing 1:1 supervision for resident watching movies/videos on their phone, especially at night. V32 stated new staff receive no training on how to handle the mentally ill population or abuse, and "they have high school students providing 1:1 supervision at night, who have zero training." V32 stated V27 will "hide" in V3's office when she is supposed to be working on the floor. V32 indicated she has come on shift to find that V27 had not given R20 her bolus tube feedings or medications. V32 stated, "I just told the Agency I couldn't work there anymore; residents are not taken care of, and there is such poor management in that building."

On 2/02/23 at 1:59 pm, V4 (Social Services) stated she left her position on 2/24/23, because "Administration was being extremely hostile to me after talking to you (State Surveyors). It was a very uncomfortable situation." V4 stated she came into her role in Social Services with no training from the facility on what her job was, what constituted abuse, or how to deal with the mentally ill population. V4 stated that V1 has known about R9's sexual behaviors. V4 stated R9 was openly discussed in the Morning Meeting with all of the Department Heads on 1/06/23. V4 stated they specifically discussed in that meeting, R9 going in and out of resident rooms at night, and that R6 reported R9 touched her sexually the day prior. V4 stated, at that time, it was

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 02/23/2023

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 43	S9999		

suggested by the team that R9 go back on 1:1 supervision or they find placement for him elsewhere. V6 stated she recalls the discussion about placing R9 on 1:1 supervision, because Management "didn't want things to escalate to a reportable incident." V4 stated the Social Service staff had also talked to both R6 and R15's family regarding their sexual relationship in December 2022. V4 stated V1 was fully aware of the situation, but V1 felt R6 and R15 had a high enough BIMS (Brief Interview for Mental Status) that they could not stop them from engaging in sex. V4 stated V1 spoke to both R6 and R15's families about their sexual relationship.

The CMS-672 (Resident Census and Conditions of Residents), dated 1/24/23 and signed by V1 (AIT), documents 116 residents currently live in the facility.

(A)

(Violation 2 of 3)

300.610a)
300.1010h)
300.1210b)
300.1210d)1)
300.2040b)2)
300.2040)e)

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

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 02/23/2023

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 44	S9999		

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 300.1010 Medical Care Policies

h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

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 care needs of the resident.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

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 02/23/2023

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 45 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. Section 300.2040 Diet Orders b) Physicians shall write a diet order, for each resident, indicating whether the resident is to have a general or a therapeutic diet. The attending physician may delegate writing a diet order to the dietitian. 2) The diet shall be served as ordered. e) A therapeutic diet means a diet ordered by the physician or dietitian as part of a treatment for a disease or clinical condition, to eliminate or decrease certain substances in the diet (e.g., sodium) or to increase certain substances in the diet (e.g., potassium), or to provide food in a form that the resident is able to eat (e.g., mechanically altered diet). These requirements were not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a resident (R20), who is non-verbal, received gastrostomy tube (g-tube) feedings for adequate nutritional intake as ordered by the physician, implement dietician recommendations to prevent further weight loss, obtain daily weights, and document dietary meal intakes to prevent significant weight loss for three of four residents (R1, R5, R20) reviewed for weight loss in the sample of 25. As a result of this failure R20 went nine days without receiving any type of nutritional intake causing her emotional/psychological distress as well as	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 02/23/2023

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 46	S9999		

pain related to hunger pains. R20 has also lost 20 lbs (11.4% weight loss) since R20 was admitted on 8/6/22 (five months).

Findings include:

The facility's Resident Weight Monitoring policy, dated 9/08, documents, "If there is an actual significant weight change, the resident, family/guardian, physician, and dietitian are notified. The date of notification for physician and family/guardian is documented on the Report of Monthly Weight form. The Food Service Manager and/or dietician reviews the resident's nutritional status and makes recommendations for intervention in the nutrition progress notes. The Food Service Manager and/or dietitian notify nursing of any recommendations that have been documented. Nursing then contacts the physician to convey recommendations and obtain any new orders. Significant unplanned weight changes are reviewed in the weekly Weight Committee Meeting. The Weight Committee will also identify any gradual weight loss or gain trends. Significant changes in weights are documented in the care plan with goals and approaches/interventions listed."

The facility's Enteral Tube Feeding Bolus Procedure policy, no date available, documents, "It is the policy of the Facility to provide nutrition via Nasogastric or Gastrostomy tubes when ordered by physician. The resident may receive nutrition and hydration either by intermittent, continuous, or bolus feeding into the stomach by means of a tube when the oral route cannot be used." The policy also documents, "Report unusual observations/findings to the physician. Report observations regarding feeding tolerance to the dietician. Document information related to

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 02/23/2023

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 47	S9999		

feeding on flow record and/or TAR (Treatment Administration Record)/MAR (Medication Administration Record)."

1. On 2/6/23 at 2:00 p.m., R20 was lying in her bed on her right side with her eyes open. When spoken to she lifted her head, made eye contact and laid back down without responding.

On 2/6/23 at 3:30 p.m., R20 was partially sitting up in bed with a flat affect and no verbalization. Questions asked to R20. R20 did not respond verbally. However, did respond at times with a thumbs up or thumbs down partially, but it was hard to understand her response. R20 became frustrated and laid back down facing the wall.

R20's Report of Monthly Weights and Vitals, dated 2022, documents R20's Admission weight on 8/6/22 was 176 lbs (pounds).

R20's Physician's orders, dated 8/22, documents that R20 was admitted on 8/6/22 with an order to receive Jevity 1.2 237 ml (milliliters) via gastrostomy tube every three hours.

R20's Dietitian Nutritional Assessment, dated 8/19/22, documents, "(R20) admitted on regular finger food diet with thin liquids and chopped meats. Tube feeding order of Jevity 1.2 237 ml via gastrostomy tube every three hours for 24 hours if (R20) eats less than 50%. 60 ml FWF (Free water flush) before and after feedings. Tube feeding order provides 2275 kcals/day, 105 g (grams) protein/day and 1530 FW/day. FWF provides 960 ml FW (Free Water)/day. No intakes available for review at this time. CBW (Current Body Weight) 176 lbs. Weight trending down since admission. (R20's) meeting estimated fluid and kcal requirements with current tube feed

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 02/23/2023

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 48	S9999		

order. Tube feed order provides above protein needs. Nurse reports encouraging resident to eat without success. (R20) is eating 0%. Tube feeding order fully utilized due to 0% intakes. Continuous feed not appropriate at this time due to (R20) attempts to elope. Recommend weekly weights. Monitor weight, intake, medications, labs, skin integrity, tube feeding tolerance."

R20's Dietary Services Communication, dated 8/22/22, documents, "Observations: Tube feeding to hold if GRV (Gastric Residual Volume) is greater than 100 ml. Aspen Guidelines state hold if tube feeding GRV is greater than 500 ml. Dietary Recommendations: Recommend discontinue current GRV order. Recommend hold tube feeding if GRV is greater than 500 ml. Recommend weekly weights." The communication also documents that R20's physician acknowledged and approved the recommendation.

R20's MAR (Medication Administration Record), dated 8/6-8/30/22, documents that R20 is to receive Jevity 1.2 237 ml via gastrostomy tube every three hours, and there is no documentation that R20 received the Jevity bolus on the following dates/times: 8/7 - 6:00 p.m., 3:00 a.m.; 8/8 - 6:00 p.m., 3:00 a.m.; 8/9 - 3:00 a.m.; 8/10 - 6:00 p.m., 9:00 p.m., 3:00 a.m.; 8/11 - 6:00 a.m., 9:00 p.m., 12:00 a.m., 3:00 a.m.; 8/12 - 3:00 p.m., 6:00 p.m., 12:00 a.m., 3:00 a.m.; 8/13 - 3:00 a.m.; 8/14 - 6:00 a.m., 12:00 p.m., 12:00 a.m., 3:00 a.m.; 8/15 - 6:00 a.m.; 8/16 - 12:00 a.m., 3:00 a.m.; 8/18 - 9:00 p.m.; 8/19 - 6:00 a.m., 12:00 a.m., 3:00 a.m.; 8/20 - 6:00 p.m.; 8/22 - 9:00 p.m.; 8/25 - 9:00 a.m., 3:00 p.m., 6:00 p.m. 9:00 p.m.; 8/30 - 6:00 p.m.; 8/31 - 9:00 p.m. for a total of 36.

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 02/23/2023

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S9999	Continued From page 49	S9999		

R20's TAR (Treatment Administration Record), dated 8/6/22-8/31/22, documents that R20 is to be a daily weight. However, during the time span of 8/6-8/31 only one weight was obtained on 8/29/22.

R20's Report of Monthly Weights and Vitals, dated 2022, documents R20's 9/22 weight was 170 lbs (6 lbs 3.4% weight loss in one month).

R20's Dietary Notes, dated 9/21/22 and signed by V40 (Registered Dietician/RD), document, "CBW 170 lbs. Gradual weight loss since admission. Regular pureed diet with thin liquids. 0% intakes recorded for three meals. Tube feeding order of Jevity 1.2 237 ml via gastrostomy tube every three hours for twenty four hours if less than 50% intakes. 60 ml FWF plus tube feeding order plus FW provides 2275 kcals/day, 105 g protein/day, 2490 FW a day. R20 meeting estimated kcal and fluid requirements with current tube feeding order. R20 tolerating tube feedings per nursing notes. Nurse reports R20 drinks but does not eat anything as per above. V40 recommendations for GRV signed last month; per nurse. Tube feeding not be held due to GRVs. Continuous feed would be appropriate overnight due to R20 receives 1:1 care. Continuous feed may assist with weight control. Recommend Jevity 1.2 at 150 ml/hour for twelve hours overnight with 200 ml FWF three times a day during feedings. Tube feeding provides 1800 ml volume/day, 2160 kcals/day, 99.9 g protein per day, 1453 FW per day. 200 ml FWF three times a day provides 600 ml FW per day. New tube feeding recommendations meet estimated nutrient needs. Monitor weight intake, medications, labs, skin integrity, tube feeding tolerance, tube feeding order."

R20's Dietary Services Communication, dated

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 50 9/21/22 and signed by V40, documents, "Observations: Nurse requests continuous feed for tube feeding. Gradual weight loss. Recommendations: Recommend Jevity 1.2 at 150 ml/hr for 12 hours overnight with 200 ml FWF three times a day during feedings." The communication also documents that the physician acknowledged and approved the recommendation on 10/20/22. R20's current medical record has no documentation of V40's 9/21/22 recommendation being followed through with until signed by the physician on 10/20/22. R20's MAR, dated 9/22, documents that R20 is to receive Jevity 1.2 237 ml via gastrostomy tube every three hours, and there is no documentation that R20 received the Jevity bolus on the following dates/times: 9/1 - 6:00 p.m.; 9/6 - 6:00 p.m., 9:00 p.m.; 9/7 - 6:00 a.m., 9:00 a.m., 12:00 p.m., 3:00 p.m., 6:00 p.m., 12:00 a.m., 3:00 a.m.; 9/8 - 9:00 p.m.; 9/10 - 9:00 p.m.; 9/11 - 12:00 a.m., 3:00 a.m.; 9/12 - 6:00 a.m., 12:00 a.m., 3:00 a.m.; 9/14 - 9:00 p.m.; 9/19 - 6:00 p.m.; 9/20 - 6:00 p.m., 9:00 p.m.; 9/21 - 6:00 a.m., 9:00 a.m., 12:00 p.m., 3:00 p.m., 12:00 a.m., 3:00 a.m.; 9/22 - 6:00 p.m.; 9/23 - 6:00 p.m.; 9/24 - 6:00 p.m.; 9/25 - 6:00 p.m., 9:00 p.m.; 9/26 - 12:00 a.m., 3:00 a.m.; 9/27 - 6:00 p.m.; 9/28 - 6:00 p.m.; 9/29 - 6:00 a.m., 12:00 a.m., 3:00 a.m.; 9/30 - 6:00 a.m. for a total of 40. R20's TAR, dated 9/22, documents that R20 is to be weighed daily as of 9/6/22 and there is no documentation of a weight being obtained on the following dates: 9/7, 9/15-9/17, 9/19-9/25, 9/29-9/30. R20's Nurses' notes, dated 9/27/22 at 12:00 p.m.,	S9999		

Illinois Department of Public Health

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 02/23/2023

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S9999	Continued From page 51	S9999		

document, "R20 continues to yell out and it is very difficult to understand her needs. Seems to be in pain." This date is also date in which there is no documentation of R20 receiving a scheduled g-tube bolus.

R20's Report of Monthly Weights and Vitals, dated 2022, documents R20's 10/22 weight was 160 lbs (10 lbs 5.9% weight loss in one month).

R20's Dietary notes, dated 10/18/22 and signed by V40, document, "CBW 163 lbs. Gradual weight loss for 30 days noted. Tube feeding order of Jevity 1.2 237 ml via gastrostomy tube every three hours for twenty four hours if less than 50% intakes. Tube feeding order plus FW provides 2275 kcals/day, 105 g protein/day, 2490 FW a day. R20 meeting estimated kcal requirements; however, receiving above protein and fluid requirements with current tube feeding order. Extra protein may be appropriate due to failure to thrive diagnosis and continued weight loss. 0% PO (by mouth) intakes recorded for three meals. V28 (Dietary Manager) confirms little to no intakes as per above. Continuous feed may assist with weight control as per previous. Recommend Jevity 1.2 at 150 ml/hour for twelve hours overnight with 200 ml FWF three times a day during feedings and 30 ml FWF twice a day before and after medications. New tube feed order provides 1800 ml volume/day. 2160 kcals/day, 99.9 g protein/day, 1453 ml FW/day. New tube feed order meets estimated nutrient needs."

R20's Dietary Services Communication, dated 10/18/22 and signed by V40, documents, "Observation: Gradual weight loss for 30 days. Tube feed bolus. Recommendations: Recommend Jevity 1.2 at 150 ml/hr for 12 hours

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 02/23/2023

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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S9999	Continued From page 52	S9999		

overnight with 200 ml FWF three times a day during feedings and 30 ml FWF twice a day before and after medications." The communication also documents that the doctor acknowledged and approved the recommendation on 10/20/22.

R20's Physician's orders, dated 10/22, document that R20 received an order on 10/20/22 for Jevity 1.2 at 150 ml/hr for 12 hours overnight with a 200 ml flush three times during feedings and a 30 ml flush twice a day before and after medications.

R20's MAR, dated 10/22, has no documentation of R20 receiving her Jevity 1.2 237 ml every three hour bolus on the following dates/times: 10/1 - 3:00 p.m., 3:00 a.m.; 10/6 - 9:00 p.m.; 10/7 - 6:00 p.m.; 10/9 - 9:00 p.m.; 10/12 - 9:00 p.m.; 10/13 - 9:00 p.m., 12:00 a.m.; 10/16 - 9:00 p.m.; 10/17 - 6:00 p.m., 12:00 a.m., 3:00 a.m.; 10/27 - 12:00 a.m., 3:00 a.m.; 10/28 - 9:00 p.m., 10/29 - 9:00 p.m.; 10/30 - 12:00 p.m., 9:00 p.m.; 10/31 - 9:00 p.m. for a total 19. R20's MAR also documents that R20's order to receive Jevity 1.2 at 150 ml/hr overnight with 200 ml FWF three times a day during feedings was not started until 10/27/22 and there is no documentation of R20 receiving the overnight feeding on 10/29 or 10/30. The as needed medication information page of R20's MAR also documents that R20 received as needed Tramadol 50 mg for yelling out/symptoms of pain twice on 10/9, 10/17, 10/27, 10/29, and 10/30 which were also days that R20 has no documentation of receiving scheduled g-tube boluses.

R20's Report of Monthly Weights and Vitals, dated 2022, documents R20's 11/22 weight was 161 lbs (15 lbs 8.5% weight loss in three months).

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 02/23/2023

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EL PASO HEALTH CARE CENTER	850 EAST SECOND STREET EL PASO, IL 61738

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S9999	Continued From page 53	S9999		

R20's MAR (Medication Administration Record), dated 11/22, documents that R20 was to receive Jevity 1.2 for twelve hours overnight at a rate of 150 ml/hr being turned on at 8:00 p.m. and turned off at 8:00 a.m. The MAR has no documentation of R20 being administered the feeding on 11/3, 11/5, 11/6, and 11/9 as well as 11/1, 11/2, 11/7, 11/8 were circled as R20's tube feeding was not administered. In the same section that this tube feeding is signed off is a handwritten statement, "On hold; pending discontinue - R20 doesn't remain still." The MAR documents that R20 was restarted on Jevity 1.5 237 ml bolus every three hours on 11/9 at 12:00 p.m. There is no documentation of R20 receiving the bolus on the following dates/times: 11/9 - 12:00 a.m. & 3:00 a.m.; 11/10 - 12:00 p.m., 3:00 p.m., 6:00 p.m., 9:00 p.m.; 11/12 - 9:00 p.m.; 11/13 - 3:00 p.m., 6:00 p.m., 9:00 p.m.; 11/14 - 12:00 a.m., 3:00 a.m.; 11/15 - 9:00 p.m., 11/16 - 6:00 a.m., 12:00 a.m., 3:00 a.m., 11/17 - 6:00 p.m.; 11/18 - 6:00 a.m., 6:00 p.m.; 11/19 - 6:00 p.m., 9:00 p.m., 12:00 a.m., 3:00 a.m.; 11/20 - 6:00 p.m.; 11/21 - 6:00 p.m.; 11/22 - 6:00 a.m.; 11/24 - 6:00 a.m., 12:00 p.m., 3:00 p.m., 6:00 p.m., 9:00 p.m.; 11/25 - 6:00 a.m., 9:00 a.m., 12:00 p.m., 3:00 p.m., 6:00 p.m.; 11/26 - 3:00 p.m.; 11/27 - 6:00 a.m., 6:00 p.m.; 11/29 - 3:00 p.m., 6:00 p.m. for a total of 41. The as needed medication information page of R20's MAR also documents that R20 received as needed Tramadol 50 mg twice on 11/5, twice on 11/6, and once on 11/9 for yelling out/symptoms of pain which were also days that R20 has no documentation of receiving any type of g-tube feeding. R20 also received the as needed Tramadol on 11/18, twice on 11/19, twice on 11/20, and on 11/25 which were days that R20 has no documentation of receiving scheduled g-tube boluses.

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 02/23/2023

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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S9999	Continued From page 54	S9999		

R20's Psychiatric Nurse Practitioner Progress note, dated 11/8/22, documents, "Assessment & Plan: Anorexia."

R20's Nurses' notes, dated 11/9/22 at 9:00 p.m., document, "Fax sent to doctor to discontinue pump feeds and continue with bolus feeds every three hours due to safety concerns related to inability to remain in bed for 12 hours."

R20's Physician notification form, dated 11/9/22, documents, "R20 has gastrostomy tube and was ordered for 12 hour of Jevity 1.2 at 50 ml/hr. R20 does not remain still and is constantly getting up and walking halls. Unsafe to be hooked to machine for any length of time. Please consider returning to bolus feeds of Jevity 1.5 237 ml every three hours." The form also documents the physician's order to refer to dietician for orders.

R20's current medical record has no documentation of V40 being notified regarding R20's continuous tube feeding being discontinued and boluses started.

R20's Dietary Notes, dated 11/16/22 and signed by V40, document, "CBW 161 lbs. Significant weight loss noted: 8.5% in 90 days. Tube feeding order of Jevity 1.2 237 ml bolus every three hours via gastrostomy tube with 60 ml FWF before and after feedings and 30 ml FWF twice a day before and after medications. Resident meeting estimated kcal and protein needs with current tube feeding order. Resident receiving above estimated fluid needs. Nurse reports continuous feed discontinued due to resident does not stay in bed for long periods of time throughout the night. Per nurse resident is tolerating feeds at this time. Recommend decrease flushes to 40 ml before and after feedings to provide 2290 ml FW/day.

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 02/23/2023

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 55 Meeting estimated fluid needs. Recommend 60 ml high calorie supplement twice a day by mouth to assist with weight control." R20's Physician's orders nor MAR, dated 11/22, have any documentation of V40's 11/16/22 recommendation being followed through with. R20's Behavior tracking, no date available however V1 verified on 2/16/23 this was R20's 11/22 behavior tracking, documents that R20's target behavior is "Inappropriate Behavior." The tracking also documents that R20 exhibited this behavior continuously on 1st shift of 11/5-11/8, 11/12, 11/14-11/15, and 11/19-11/21. 11/5-11/8/22 were four days that the facility has no documentation of R20 receiving any type of g-tube feeding. There is also no documentation of R20 receiving scheduled bolus doses on 11/14, 11/15, 11/19 and 11/20/22. R20's Report of Monthly Weights and Vitals, dated 2022, documents R20's 12/22 weight was 157 lbs (4 lbs in one month, 13 lbs 7.6% weight loss in three months). R20's Dietary notes, dated 12/13/22 and signed by V40, documents, "CBW 157 lbs. Significant weight loss noted: 7.65% in 90 days. Weight trending down in 30 days. Refusals documented for three meals. Tube feeding order of Jevity 1.2 237 ml bolus every three hours via gastrostomy tube with 60 ml FWF before and after feedings and 30 ml FWF twice a day before and after medications. Resident meeting estimated kcal and protein requirements with current tube feeding order. Recommend: 90 ml high calorie supplement twice a day due to continued weight loss. Discussed continued weight loss with Director of Nursing who would like to trial bolus	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 02/23/2023

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 56	S9999		

feeds four times a day. Recommend Jevity 1.2 474 ml bolus four times a day with 40 ml FWF before and after feedings and 30 ml FWF twice a day before and after medications. Meets estimated nutrient needs."

R20's Dietary Services Communication, dated 12/14/22 and signed by V40, documents, "Observations: Tube feeding. 7.65% weight loss in 90 days. Recommendations: Jevity 1.2 474 ml bolus four times a day with 40 ml FWF before and after feedings and 30 ml FWF before and after medications. 90 ml high calorie supplement twice a day." The communication also documents that R20's physician acknowledged and approved the recommendation.

R20's MAR, dated 12/22, has no documentation of R20 receiving her Jevity 1.5 237 ml every three hour bolus on the following dates/times: 12/3 - 6:00 a.m., 6:00 p.m.; 12/4 - 3:00 p.m., 6:00 p.m.; 12/7 - 9:00 p.m.; 12/13 12:00 a.m., 3:00 a.m.; 12/17 - 6:00 a.m., 6:00 p.m., 9:00 p.m.; 12/19 - 6:00 p.m.; 12/21 - 6:00 p.m., 9:00 p.m.; 12/22 - 9:00 p.m.; 12/26 - 3:00 p.m. for a total of 15. R20's MAR also has no documentation of R20 receiving 60 ml of high calorie supplement twice a day nor the 12/13/22 recommendations of 90 ml of high calorie supplement twice a day due to continued weight loss. The as needed medication information page of R20's MAR also documents that R20 received as needed Tramadol 50 mg twice on 11/5, twice on 11/6, and once on 11/9 for yelling out/symptoms of pain which were also days that R20 has no documentation of receiving any type of g-tube feeding. R20 also received the as needed Tramadol on 11/18, twice on 11/19, twice on 11/20, and on 11/25 which were days that R20 has no documentation of receiving scheduled g-tube boluses.

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 02/23/2023

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S9999	Continued From page 57 R20's TAR, dated 12/22, documents that R20 should be daily weights, however there is no documentation of any weights obtained for the month of December. R20's TAR, dated 1/23, documents that R20 is to be weighed on a daily basis, however no weights are documented for 1/1-1/4. R20's most recent weight documented was 156 lbs (weight loss of 11.4% since admission-five months) on 1/19/23, and then this order was discontinued on 1/20/23. R20's Dietary Services Communication, dated 1/19/23 and signed by V40, documents, "Observation: Tube feeding assessment. Dietary recommendations: Jevity 1.5 375 ml bolus four times a day with 90 ml FWF before and after feedings and 30 ml FWF before and after medications." The communication also documents that R20's physician acknowledged and approved the recommendation on 1/20/23. R20's MAR, dated 1/23, documents from 1/7-1/20 R20 had an order to receive Jevity 1.2 474 ml bolus four times a day, and there is no documentation of R20 receiving the bolus on 1/11 at 6:00 a.m. and 12:00 a.m. The MAR also documents that this order was discontinued on 1/20/23 and Jevity 1.5 375 ml bolus four times a day was started. There is no documentation of R20 receiving that bolus on 1/21 at 6:00 p.m. or 1/30 at 12:00 p.m. Also, R20's dietician recommendation to initiate 90 ml of high calorie supplement twice a day was started on 1/7/23, however it was discontinued on 1/20/23. R20's Medical record has no documentation of an order to discontinue R20's 90 ml of high calorie supplement twice a day on 1/20/23.	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 02/23/2023

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 58	S9999		

R20's Physician's orders, dated 2/23, document that R20 has an order dated 1/20/23 to receive Jevity 1.5 375 ml bolus four times a day via gastrostomy tube. However, there is no documentation of R20 having an order to receive the high calorie supplement 90 ml twice a day.

R20's MAR, dated 2/23 obtained on 2/6/22 at 3:00 p.m., documents that R20 has an order to receive Jevity 1.5 375 ml bolus four times a day. The MAR also documents that as of 2/6/23, there is no documentation that R20 received her bolus on 2/4 at 6:00 p.m. and 12:00 a.m. and 2/5 at 6:00 a.m. and 12:00 a.m. nor that she received the high calorie supplement 90 ml twice a day from 2/1-2/6/23.

R20's care plan, dated 8/19/22, has no documentation of a revision to include R20's significant weight loss.

On 2/04/23 at 11:10 am, V32 (Registered Nurse/RN) stated, "(V27/Licensed Practical Nurse/LPN) was not feeding (R20) who was to get a tube feed. Several weeks ago, I came on shift and (V27) was giving me report. She was saying how (R20's) tube feeding had been infusing all night. I started to question her, because (R20) didn't have an infusion pump or continuous feeding. (V27) argued that (R20) did have an infusion pump and I just let it go. As soon as (V27) left, I went to (R20's) room. The door was closed. I was right, they didn't' start (R20) on continuous pump, she was still on bolus feedings. (R20) can't talk much, but can say 'yes' or 'no.' She was really agitated when I went in her room, needed oral care, it was obvious it hadn't been done. I asked (R20) if she got fed by the nurse before me and she indicated 'No.' So I gave her

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 02/23/2023

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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S9999	Continued From page 59	S9999		

her feeding. When I went to the MAR, it was signed off by (V27) as being given. Honestly, I don't think (V27) went into her room all night. We don't even have a tube feeding pump in the building. (R20's) behaviors will increase because she is hungry; I've seen it other times. I will come in and she will be agitated, and her feedings will not be documented as given. As soon as I feed her, her agitation stops."

On 2/7/23 at 12:00 p.m., V11 (RN) stated, "There was an issue with the facility getting a tube feeding pump when we first got the order. So, it wasn't started right away. I actually spoke with (V40) myself to try and do something different than boluses every three hours because when it's busy it's not easy to get them done every three hours. If you missed one dose by getting sidetracked or busy by the time you were able to do it, she was due for her next one. So, she might miss a dose."

On 2/7/23 at 12:40 p.m., V40 (RD) stated, "(R20) should not be losing weight with the amount of calories and protein that she gets on a daily basis from her tube feedings. It gets frustrating. I make recommendations and they don't get followed up with. I added the high calorie supplement twice a day hoping that would help. I was not notified when they changed the tube feeding from continuous overnight back to the boluses. I didn't know about it until I came in for my monthly visits. They should have consulted with me about what to put her on."

On 2/7/23 at 1:20 p.m., V24 (Registered Nurse) stated, "I don't work that hall too often. The facility was having difficulty getting the right equipment for (R20's) continuous feeding. We didn't have the equipment until the night of the 9th. I was the

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 02/23/2023

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 60	S9999		

first one to hook her up for the feeding when we had the right equipment. I attempted to do the feeding and she wouldn't stay in the bed, and she was wanting to leave the room. The tubing was stretching, and it just wasn't working. So I contacted the doctor about getting them stopped and switched back to the bolus feedings. I did the bolus feedings as she previously had ordered. I mentioned it to the other nurses that nobody was signing out a bolus feed, but they were circling that the continuous feed wasn't getting done. It looks like we aren't feeding her. I don't know that all of the nurses were giving her the normal schedule of bolus feeding during that time. I know it wasn't on the MAR to give them. I was terrified to put my name in the book, so I contacted the doctor. If it's not signed off in the MAR, then you can only assume it's not done. I don't know of anyone notifying the physician prior to that evening. I don't know that (R20) always gets her feedings or if she does if they are late. I don't want to assume, but her behaviors are escalated when I suspect it. It seems like she has an increase in behaviors. She complains of pain at times too. She will normally tell me she has a headache which could be part of hunger pains. She doesn't eat, and then nurses may not be giving her all of her boluses. This breaks my heart. She can't verbalize. She can't tell us that she is hungry."

On 2/7/23 at 4:10 p.m., V41 (Medical Director) stated, "(R20) should not have gone without receiving her tube feedings. I agree that these issues needed to be addressed. The DON (Director of Nursing) should be overseeing these things and making sure they are followed through with. However, I know they haven't had a DON for a while. I should have been notified when the facility wasn't able to get the tube feeding

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 02/23/2023

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 61	S9999		

supplies and (R20) went without feedings before 11/9/22."

On 2/8/22 at 10:15 a.m., V11 (RN) stated, "I know I don't give her high calorie supplement 90 ml with any of my medication passes." V11 confirmed there is no order on the 2/23 MAR for (R20) to receive high calorie supplements at all. V11 stated, "(R20) doesn't have many behaviors. When she first got here, she was exit seeking mainly. Now though she will sit on the floor; she learned that from an old roommate. Now the only thing I really notice is the yelling out occasionally. Sometimes, if you ask her, she will say she's having pain; she will shake her head 'yes.' Sometimes, I feel like her yelling out is related to her feedings. I will ask her if she's hungry and she will say 'yes' at times. The yelling out is sometimes when she's due for a feeding as well. There's times too that it's hard to understand what she wants because she will shake her head 'yes' and 'no' to respond to our questions, but sometimes 'yes' looks like 'no' and 'no' looks like 'yes,' and I can't decipher what is wrong."

On 2/8/22 at 5:20 p.m., V1 (AIT) stated, "(R20's) high calorie supplement was discontinued (1/20/23) in error by one of the nurses. There was no physician order to discontinue the high calorie supplement."

On 2/1/23 at 2:25 p.m., V28 (Dietary Manager) stated, "Significant weight loss is 5 lbs or more in one month. I don't know the significant weight loss percentages. The CNAs are responsible for charting the residents' intakes at meals. I use the meal intakes for my quarter assessments. I've noticed lots of holes where meals are not charted. I let the nursing department know about it."

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 02/23/2023

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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S9999	Continued From page 62 On 2/16/23 at 11:35 a.m., V48 (Director of Nursing) stated, "The doctor and the dietician should have been notified prior to 11/9 that there was no equipment to administer (R20's) continuous feeding. They should have known that we had to keep the boluses going, and then contacted letting them know when the continuous feeding was actually started. The boluses should have continued until the continuous feeding was started. I don't see where (R20) got any type of feeding from 11/1-11/9." V48 also confirmed the lack of documentation on R20's MAR for R20 receiving g-tube feedings. V48 confirmed dietician recommendations that were not followed through with and stated, "I don't know what the process was for processing and following through with the dietician recommendations, but they weren't being followed through with. The CNAs are responsible for charting the meal intakes. I haven't had a chance to look at the meal intake charting, but that is what we will refer to when a resident is having weight loss. We first off need to know if a resident is eating or not." V48 confirmed the lack of documentation on the meal intakes and MAR for R20's g-tube feedings. 2. R1's Food & Fluid Intake, dated 10/22, documents no meal intakes documented on the following dates: 10/6 supper, 10/7-10/8 all three meals, 10/11 breakfast & lunch, 10/12 all three meals, 10/14 all three meals, 10/15 lunch & supper, 10/16 all three meals, 10/18 all three meals, 10/19-10/20 breakfast & lunch, 10/23-10/24 all three meals, 10/25 breakfast & lunch, 10/26-10/27 all three meals, 10/28 lunch & supper, 10/29 supper, 10/30 breakfast & lunch, and 10/31 supper. The intake form has no documentation of R1 receiving snacks, including bedtime snacks, or supplements for the entire month of October.	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 02/23/2023

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 63 R1's Report of Monthly Weights and Vitals, dated 2022, documents the following weight: 11/22 204 lbs (pounds). R1's Dietary Services Communication, dated 11/18/22, documents, "Observation: Gradual weight loss. Dietary Recommendations: 4 oz mighty high calorie high protein shake at lunch." This communication has no documentation that the physician nor R1's representative was notified of this recommendation. R1's Food & Fluid Intake, dated 11/22, documents no meal intakes documented on the following dates: 11/1 breakfast & lunch, 11/2 all three meals, 11/4-11/5 supper, 11/6 lunch & supper, 11/7 supper, 11/8 breakfast, 11/10-11/12 supper, 11/13-11/8 all three meals, 11/21-11/23 all three meals, 11/25 all three meals, 11/26 supper, 11/27 all three meals, 11/28 supper, 11/29 breakfast & lunch, and 11/30 all three meals. The intake form has no documentation of R1 receiving snacks, including bedtime snacks, or supplements for the entire month of November. R1's Report of Monthly Weights and Vitals, dated 2022, documents the following weight: 12/22 199 lbs (pounds) which is a 17 lbs and 7.9% weight loss in three months (9/22 216 lbs). R1's Dietary Services communication, dated 12/14/22, documents, "Observation: 7.8% weight loss in 90 days. Dietary Recommendations: 4 oz high protein high calorie shake twice a day." This communication has no documentation that the physician nor R1's representative was notified of this recommendation. R1's POS (Physician's Order Sheet), dated	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 02/23/2023

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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S9999	Continued From page 64 12/22, documents that an order was obtained on 12/7/22 to start 4 oz of a high calorie high protein shake at lunch. R1's Food & Fluid Intake, dated 12/22, documents no meal intakes documented on the following dates: 12/3 lunch, 12/4 Supper, 12/6 Supper, 12/7 lunch and supper, 12/8-12/11 supper, 12/12-12/13 all three meals, 12/14 lunch and supper, 12/15 all three meals, 12/16 supper, 12/17 all three meals, 12/19-12/20 supper, 12/21 all three meals, 12/22 supper, 12/23-12/26 all three meals, 12/27 lunch and supper, 12/28 all three meals, 12/29-12/30 supper. The intake form has no documentation of R1 receiving snacks, including bedtime snacks, or supplements for the entire month of December. R1's MAR, dated 12/2022, documents that R1 is to receive 4 oz of a high protein high calorie shake at lunch (12 pm) that was initiated on 12/7/22 and a high calorie high protein supplement daily. The MAR has no documentation of R1 receiving the shake on 12/15, 12/20, or 12/30/22 nor was it documented that R1 received the supplement on 12/2, 12/25, or 12/27/22. R1's Report of Monthly Weights and Vitals, dated 2023, documents that R1's 1/23 weight is 188 lbs. R1 weight is a 11 lbs and 5.5% in weight loss in one month (12/22 199 lbs), 19 lbs and 9.2% weight loss in three months (10/22 207 lbs), and 31 lbs and 14.2% weight loss in six months (7/22 219 lbs). R1's MAR, dated 1/23, documents that from 1/1 to 1/6/23 R1 was receiving a high protein high calorie shake once a day, and then starting 1/7/23 it was increased to twice a day until she	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 02/23/2023

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 65	S9999		

was sent to the emergency room on 1/16/23.

R1's Care plan, dated 9/9/22, documents, "Potential risk for altered nutritional status and/or weight loss as evidenced by pattern of slow weight loss." The care plan has no documentation of revisions to R1's care plan to address R1's significant weight loss.

R1's Hospital History & Physical, dated 1/17/23, documents that R1's Albumin laboratory value was 3.3 low (Normal 3.4-5.4)

On 2/1/23 at 2:25 p.m., V28 (Dietary Manager) stated, "(R1) had a dietary recommendation on 9/22/22 for a 60 ml high calorie high protein supplement. This is the supplement that the nurses pass. In November the dietician recommended a high calorie high protein shake once a day, and in December a high calorie high protein shake twice a day. I don't know if these were followed through with or not."

3. Report of Month Weights and Vitals, dated 2022, document that R5's weight in 10/22 was 165 lbs. This was a weight loss of 23 lbs and 12.2% in six months (4/22 188 lbs).

R5's Food & Fluid Intake Sheet, dated 10/22, has no documentation of R5 receiving any snacks or supplements for the month of October. The sheet also has no documentation of R5's intake for the following meals: 10/6-10/7 supper, 10/8 all three meals, 10/12 supper, 10/14 supper, 10/15 lunch & supper, 10/16 all three meals, 10/18 all three meals, 10/19-10/20 breakfast & lunch, 10/23-10/24 all three meals, 10/25 breakfast & lunch, 10/26-10/27 all three meals, 10/28 lunch & supper, 10/29 supper, 10/30 breakfast & lunch, 10/31 supper.

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 02/23/2023

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 66	S9999		

R5's Dietary notes, dated 10/18/22, document, "Registered Dietician Monthly weight note. Current Body weight 165 lbs. Significant weight loss noted: 12.23% in 180 days. Referral to speech therapy due to swallowing difficulty. Order to downgrade diet as needed. Dietary manager reports R5 has downgraded to pureed for one day and is now receiving mechanical soft (no documentation). Per dietary manager, R5 is not eating well, but is doing better now due to receiving assistance at meals. Recommend high protein high calorie ice cream cup at lunch due to weight loss."

R5's Dietary Services Communication, dated 10/18/22, documents, "Observations: 12.23% weight loss in 180 days. Dietary Recommendations: Recommend chocolate high calorie high protein ice cream cup at lunch." The form also documents that the physician acknowledged the recommendation and approved it on 10/20/22.

Report of Month Weights and Vitals, dated 2022, document that R5's weight in 11/22 was 158 lbs. This was a 17 lbs and 9.9% weight loss in three months (8/22 175 lbs) and 26 lbs and 14.1% weight loss in six months (5/22 184 lbs).

R5's Food & Fluid Intake Sheet, dated 11/22, has no documentation of R5 receiving any snacks or supplements for the month of November. The sheet also has no documentation of R5's intake for the following meals: 11/4-11/7 supper, 11/10-11/18 supper, 11/21-11/23 supper, and 11/30 all three meals.

R5's Dietary notes, dated 11/16/22, document, "RD monthly weight note. Current body weight

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 02/23/2023

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 67 158 lbs. Significant weight loss noted: 9.71% in 90 days, 14.13% in 180 days. Weight trending down in 30 days. Speech therapy working with R5 due to dysphagia and skill training in safe swallowing strategies. Recommend chocolate magic cup and lunch and 4 oz might shake at supper due to weight loss and poor intake." Report of Month Weights and Vitals, dated 2022, document that R5's weight in 12/22 was 146 lbs. This was a 12 lbs and 7.6% weight loss in one month (11/22 158 lbs), 25 lbs and 14.6% weight loss in three months (9/22 171 lbs), and 33 lbs and 18.4% in six months (6/22 179 lbs). R5's Food & Fluid Intake Sheet, dated 12/22, has no documentation of R5 receiving any snacks or supplements for the month of December. The sheet also has no documentation of R5's intake for the following meals: 12/1 supper, 12/3 lunch, 12/4 supper, 12/6 supper, 12/7 lunch & supper, 12/8-12/11 supper, 12/12-12/13 all three meals, 12/14-12/16 supper, 12/17 all three meals, 12/18-12/21 supper, 12/22-12/26 all three meals, 12/27 lunch & supper, 12/28 all three meals, 12/30 supper. R5's Dietary Notes, dated 12/14/22, document, "RD monthly weight note. Current body weight 146 lbs. Significant weight loss noted: 7.59% x 30 days, 14.62% in 90 days, 18.44% in 180 days. Recommend chocolate magic cup at lunch and 4 oz mighty shake twice a day due to weight loss. Monitor weight, intake. Recommend weekly weights for four weeks." R5's Dietary Services Communication, dated 12/14/22, documents, "Observation: 7.59% in 30 days, 14.62% in 90 days, 18.44% in 180 days weight loss. Dietary recommendations: high	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 02/23/2023

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 68	S9999		

calorie high protein ice cream cup at lunch, 4 oz high calorie high protein shake twice a day, weekly weights for four weeks." The communication was signed by the physician approving the dieticians' recommendations. The form also documents that this document was noted on 1/6/23, and there is no documentation of V44 (R5's POA/Power of Attorney) being notified.

R5's MAR & TAR (Treatment Administration Record), dated 12/22, have no documentation of weekly weights being obtained for R5.

R5's Report of Month Weights and Vitals, dated 2023, document that R5's weight in 1/23 was 140 lbs. This was a 25 lbs and 15.2% weight loss in three months (10/22 165 lbs) and 36 lbs and 20.5% weight loss in six months (176 lbs).

R5's TAR, dated 1/23, documents R5 should have weekly weights done, and as of 1/24/23 two weights were completed for the month of January.

R5's Food & Fluid Intake Sheet, dated 1/23 has no documentation of R5 receiving any snacks or supplements for the month of December. The sheet also has no documentation of R5's intake for the following meals: 1/2/ all three meals, 1/4/ all three meals, 1/5 supper, 1/6 breakfast & supper, 1/7-1/8 breakfast & lunch, 1/10 lunch & supper, 1/12 lunch & supper, 1/14-1/15 lunch & supper, 1/17-1/18 lunch & supper, 1/19 lunch, 1/21-1/22 lunch & supper.

R5's Dietary Note, dated 1/18/23, documents, "RD Monthly weight note: CBW 140 lbs. Significant weight loss noted: 15.15% in 90 days. 20.45% in 180 days. Weight trending down in 30 days. Recommend 4 oz high calorie high protein

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 02/23/2023

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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S9999	Continued From page 69	S9999		

shake three times a day."

R5's Diet order form, dated 1/20/23, documents that R5 had a diet change for R5 to receive 4 oz of high calorie high protein shake three times a day.

R5's Dietary notes, dated 1/24/23 and signed by V28, document, "Dietary recommendation for R5 to receive a 4 oz high calorie high protein shake three times a day has been approved. Diet card will be updated to show the change."

R5's MAR, dated 1/23, documents that R5 is receiving a high calorie high protein ice cream cup that was started on 1/6/23, and a high calorie high protein shake twice a day with breakfast and lunch. The MAR, as of 1/24/23, has no documentation of R5 receiving the high calorie high protein ice cream cup on 1/14, 1/15, or 1/18, nor receiving the high calorie high protein shake on 1/9 8:00 a.m., 1/14 12:00 p.m., 1/15 12:00 p.m., or 1/16 12:00 p.m.

On 1/24/23 at 12:50, V20 (Unit Aide) was assisting R5 with her meal of mechanical soft Swiss steak, cheesy potatoes, carrots, cake, and a high calorie high protein ice cream cup magic cup. V20 confirmed that R5 did not have a high calorie high protein shake.

On 1/24/23 at 1:05 p.m., V11 (Registered Nurse) stated, "We sign off that the residents get high calorie high protein shakes, but that is the dietary department who serves them, not nursing." Opening her MAR (Medication Administration Record), V11 pointed to R5's MAR that documents R5 is to get high calorie high protein shakes twice a day at breakfast and lunch. V11 stated, "We take the order from the dietician's

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 02/23/2023

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EL PASO HEALTH CARE CENTER	850 EAST SECOND STREET EL PASO, IL 61738

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S9999	Continued From page 70	S9999		

recommendations and then give them to the dietary department." V11 confirmed that R5 got an order to increase her high calorie high protein shakes to three times a day at all meals on 1/20/23, and she is ordered to get high calorie high protein ice cream at lunch as well.

On 1/24/23 at 1:10 p.m., V28 (Dietary Manager) stated, "I'm behind on my dietary recommendations from 1/18 and 1/19. I'm working on them today."

On 1/25/23 at 12:10 p.m., V18 (Certified Nursing Assistant/CNA) was assisting R5 with her meal of grilled cheese, mashed potatoes, mixed fruit, yogurt, apple juice, and orange juice. R5 was not served a high calorie high protein shake or high calorie high protein ice cream cup as confirmed by V18.

On 1/26/23 at 112:20 p.m., V17 (CNA) was assisting R5 with her meal of a grilled cheese, chocolate oatmeal pie, and yogurt. R5 was not served a high calorie high protein shake or high calorie high protein ice cream cup as confirmed by V17.

On 2/1/23 at 12:25 p.m., R5 was served pureed macaroni and cheese and pork, pureed beets, chocolate pudding and nectar thick liquids. V8 (CNA) was coming from the kitchen with a pureed peanut butter and jelly sandwich for R5. R5 was not served a high calorie high protein shake or high calorie high protein ice cream cup as confirmed by V8.

On 2/1/23 at 2:25 p.m. V28 stated, "(R5) got a diet order on 11/11/22 for a high calorie high protein ice cream cup at lunch. This was an order from her October dietician recommendation. In

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 02/23/2023

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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S9999	Continued From page 71	S9999		

November, the dietician suggested a high calorie high protein ice cream cup at lunch again and a high calorie high protein shake at supper. In December, the dietician suggested a high calorie high protein ice cream cup again at lunch time and a high calorie high protein shake twice a day as well as weekly weights for four weeks. I don't know why she recommended a high calorie high protein ice cream cup repeatedly each month. The weekly weights are documented on the TAR (Treatment Administration Record)." V28 confirmed no weekly weights were documented on R5's December TAR or MAR. V28 stated, "(R5's) weekly weights on her January MAR with it starting 1/6/23, but for the month of January she only has two weights on there. In January, the dietician suggested a high calorie high protein shake three times a day. I didn't put this into place until 1/24/23 when I updated her diet card. I wasn't aware that the dietary staff are not serving (R5) her high calorie high protein shakes or high calorie high protein ice cream cup at lunch. It is on her diet card so they should be doing it."

R5's Nutrition Care plan, dated 8/16/21, has no documentation of a revision to reflect R5's significant weight loss.

On 2/2/23 at 12:50 p.m., V40 (RD) stated, "If I repeatedly recommended that (R5) get a magic cup at lunch time each month, then the previous month's recommendation wasn't followed."

On 1/25/22 at 3 p.m., V44 (R5's POA) stated, "I didn't know she was losing weight until I saw her at the neurologist appointment in November (2022) and she looked thinner than I'd ever seen her. She is like skin and bones compared to what she was before. Each time I see her I feel like she is skinnier and skinnier. From the time of her

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 02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 72	S9999		

neurologist appointment to her MRI appointment (12/22/22) she lost more weight."

On 2/8/23 at 1:50 p.m., V3 (Resident Care Coordinator/Acting DON) stated, "The physician should be notified by the nurses immediately of weight loss. The dietician is notified when she comes in for her monthly visit. Once the dietician makes a recommendation it is sent to the doctor to approve it. When the doctor approves it, the nurses process the order and pass it on to dietary. I'm in charge of overseeing the nurses, not dietary. If dietary doesn't do anything with the order from the nurses, I can't do anything about it. I don't supervise the dietary department. I have no say in what happens to it after the nurses process the order, and I don't follow up with it. The CNAs do all of the weights then they give them to V6 (CNA), who logs them in their chart. The nurses should be documenting the weekly and daily weights in the TARs as well. CNAs should be documenting each residents' intake after each meal. I was not aware that intakes were not being documented. Weight loss cannot be fully assessed if there are not intakes documented or the weekly/daily weights. Nurses should be documenting when they administer medications or treatments on their MARs and TARs. If they don't sign it off, we don't know if it was done. The rule of thumb is if no signature, then it wasn't done."

On 2/16/23 at 11:35 a.m., V48 (Director of Nursing) confirmed that R1, R5, and R20's dietician recommendations were not followed through with and stated, "I don't know what the process was for processing and following through with the dietician recommendations, but they weren't being followed through with. The CNAs are responsible for charting the meal intakes.

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	IL6002745	A. BUILDING: ______ B. WING ______	C 02/23/2023

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S9999	Continued From page 73	S9999		

That is what we will refer to when a resident is having weight loss. We first off need to know if a resident is eating or not." V48 confirmed the lack of documentation on the meal intakes for R1, R5, and R20.

(A)

(Violation 3 of 3)

300.610a)
300.1210b)
300.1210d)2)

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

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S9999	Continued From page 74	S9999		

plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

2) All treatments and procedures shall be administered as ordered by the physician.

These requirements were not met as evidenced by:

Based on interview and record review, the facility failed to obtain laboratory draws as ordered by a physician for one of three residents (R1) reviewed for laboratory values in the sample of 25. This failure resulted in R1 being hospitalized with a critically low Valproic acid level.

Findings include:

The facility's Laboratory Tests policy, no date available, documents, "Laboratory testing will be completed in collaboration with Medicare guidelines, pharmacy recommendations, and physician orders. Obtain laboratory orders upon admission, readmission, and PRN (as needed) for medication and condition monitoring per the physician's orders."

R1's Physician's orders, dated 10/22, document the following orders: 10/18/22 Increase Depakote to 1125 mg by mouth three times a day. Check Depakote (Valproic Acid) level in one week.

R1's most recent Valproic blood level, dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 75 9/30/22, documents a level of 46 low (Normal 50-100). The facility was unable to provide any Valproic acid levels after this date. R1's Hospitalist Admission History and Physical, dated 1/17/23, documents, "R1 with severe schizophrenia, tardive dyskinesia, seizure disorder brought in from facility with complaints of lethargy and worsening tremors. R1 is lethargic, barely responsive, and thus unable to contribute to the history. History was obtained from emergency department records and from her mother at the bedside. The History & Physical also documents, "Depakote level is subtherapeutic." R1's Hospital Progress note, dated 1/19/23, documents that R1's Valproic Acid is less than 13 (Normal 50-125). On 2/2/23 at 9:30 a.m., V1 (AIT) confirmed that R1's most recent Valproic acid level was drawn on 9/30/22. On 2/8/23 at 1:50 p.m., V3 (Resident Care Coordinator/Acting Director of Nursing) stated, "The laboratory comes to our facility every Monday, Wednesday, and Friday unless it is a stat (as soon as possible) order. If it is stat, they come right away. If the physician orders for a lab to be drawn I would expect it to be done on the next scheduled lab draw day." (A)	S9999		