

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3001120		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/10/2026	
NAME OF PROVIDER OR SUPPLIER El Paso Rehabilitation and Health Care Center				STREET ADDRESS, CITY, STATE, ZIP CODE 850 EAST SECOND STREET , EL PASO, Illinois, 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) COMPLETION DATE	
S0000	Initial Comments		S0000				
	Change of Ownership, First Probationary Licensure Survey						
S9999	Final Observations		S9999				
	Statement of Licensure Violations:						
	1 of 8						
	300.661						
	Section 300.661 Health Care Worker Background Check						
	A facility shall comply with the Health Care Worker Background Check Act and the Health Care Worker Background Check Code.						
	(Source: Amended at 45 Ill. Reg. 11096, effective August 27, 2021)						
	(225 ILCS 46/15)						
	Sec. 15. Definitions. In this Act:						
	"Initiate" means obtaining from a student, applicant, or employee his or her social security number, demographics, a disclosure statement, and an authorization for the Department of Public Health or its designee to request a fingerprint-based criminal history records check; transmitting this information electronically to the Department of Public Health; conducting Internet searches on certain web sites, including without limitation the Illinois Sex Offender Registry, the Department of Corrections' Sex Offender Search Engine, the Department of Corrections' Inmate Search Engine, the Department of Corrections Wanted Fugitives Search Engine, the National Sex Offender Public Registry, and the List of Excluded Individuals and Entities database on the website of the Health and Human Services Office of Inspector General to determine if the applicant has been adjudicated a sex offender, has been a prison inmate, or has committed Medicare or Medicaid fraud, or conducting similar searches as defined by rule; and having the student, applicant, or employee's fingerprints collected and transmitted electronically to the Illinois State Police.						

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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S9999	Continued from page 1 This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure required background checks were completed prior to or at the time of hire for three employees (V4–V6), resulting in delayed completion of mandatory sex offender, criminal, and exclusion database checks. This failure places residents at risk of exposure to unverified staff working directly with 88 residents. Findings include: The facility's Daily Staffing Report dated 3/9/26 documents 88 residents reside within the facility. The facility's Abuse, Prevention, and Prohibition Policy dated 11/25 documents, "Screening: All employees will have criminal background checks, state and federal required checks, employment reference checks and license/certification confirmation." 1.The Facility's Employee Roster documents V4 (CNA) was hired on 1/19/26. Office of Inspector General Search Engine26, including the Illinois Sex Offender Registry, the Illinois Department of Corrections' Sex Offender Registry, the Illinois Department of Corrections' Inmate Search Engine, the Illinois Department of Corrections' Wanted Fugitive Search Engine, the National Sex Offender Public Registry, and the Health and Human Services Office of Inspector General Search Engine, were not completed until 1/21/26 (two days after V4 was hired). 2.The Facility's Employee Roster documents V5 (CNA) was hired on 1/26/26. V5's Website Background Checks dated 1/30/26, including the Illinois Sex Offender Registry, the Illinois Department of Corrections' Sex Offender Registry, the Illinois Department of Corrections' Inmate Search Engine, the Illinois Department of Corrections' Wanted Fugitive Search Engine, the National Sex Offender Public Registry, and the Health and Human Services Office of Inspector General Search Engine, were not completed until 1/30/26 (four days after V5 was hired). 3. The Facility's Employee Roster documents V6 (CNA) was hired on 1/12/26. V6's Website Background Checks dated 1/21/26,including the Illinois Sex Offender Registry,			S9999			

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S9999	Continued from page 2 the Illinois Department of Corrections' Sex Offender Registry, the Illinois Department of Corrections' Inmate Search Engine, the Illinois Department of Corrections' Wanted Fugitive Search Engine, the National Sex Offender Public Registry, and the Health and Human Services Office of Inspector General Search Engine, were not completed until 1/21/26 (nine days after V6 was hired). On 3/9/26 V25 (Assistant Administrator) verified V4-V6's Website Background Checks were not completed prior to V4-V6's date of hire. On 3/10/26 at 1:15 PM V2 (Director of Nursing) stated all CNAs work the entire building and take care of all 88 residents. (C) 2 of 8 300.670a) 300.670c)1) Section 300.670 Disaster Preparedness a) For the purpose of this Section only, "disaster" means an occurrence, as a result of a natural force or mechanical failure such as water, wind or fire, or a lack of essential resources such as electrical power, that poses a threat to the safety and welfare of residents, personnel, and others present in the facility. c) Fire drills shall be held at least quarterly for each shift of facility personnel. Disaster drills other than fire shall be held twice annually for each shift of facility personnel. Drills shall be held under varied conditions to: 1) Ensure that all personnel on all shifts are trained to perform assigned tasks; 3) Evaluate the effectiveness of disaster plans and procedures. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to ensure disaster drills were performed twice annually for each shift of facility personnel. This failure has the potential to affect all 88 residents residing within the facility. Findings include: The facility's Daily Staffing Report dated 3/9/26	S9999					

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S9999	Continued from page 3 documents 88 residents reside within the facility. The facility's annual Disaster Drills were reviewed from 3/8/25 through 3/8/26 and document only two disaster drills were performed during day shift only on 6/18/25 and 7/17/25. On 3/10/26 at 10:00 AM V1 (Administrator) stated, "We (the facility) did two disaster drills within the last year. One drill was done on 6/18/25 and one drill was done on 7/17/25. I was not aware that disaster drills had to be performed twice annually on each shift. I have not been told that in all of the time I have been an administrator." On 3/10/26 at 10:50 AM V1 verified both disaster drills performed on 6/18/25 and 7/17/25 were done for first shift staff. (C) 3 of 8 300.1060c) Section 300.1060 – Vaccinations c) A facility shall provide or arrange for administration of a pneumococcal vaccination to each resident who is age 65 or over, in accordance with the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, who has not received this immunization prior to or upon admission to the facility unless the resident refuses the offer for vaccination or the vaccination is medically contraindicated. (Section 2-213 of the Act) d) A facility shall document in each resident's medical record that a vaccination against pneumococcal pneumonia was offered and administered, refused, or medically contraindicated. (Section 2-213 of the Act) (Source: Added at 29 Ill. Reg. 12852, effective August 2, 2005) These requirements were not met as evidenced by: Based on interview and record review the facility failed to offer and/or administer a pneumococcal immunization for one of five residents (R2), reviewed for immunizations, in a sample of 80. Findings include: The (undated) facility policy, Influenza and Pneumonia Immunization directs staff, "The Advisory Committee on Immunization Practices recommends	S9999					

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S9999	Continued from page 4 vaccinating persons who are at high risk for serious complications from influenza and/or pneumonia, including those 50 years of age and older, who are residents of nursing homes. All (residents) admitted throughout the year will be offered the pneumovax injection as desired by the resident and approved by the primary care physician after investigation/inquiry related to current immunization status." R2's Physician Order Summary report, dated 3/10/26 documents that R2 was admitted to the facility on 3/6/25 with the following diagnoses: Morbid Obesity, Obstructive Sleep Apnea, Chronic Obstructive Pulmonary Disease and Heart Failure. R2's facility Immunization Report contains no documentation that R2 was screened, offered or administered a pneumonia immunization. On 3/10/26 at 11:30 A.M., V12/Infection Preventionist (IP) verified that she did not screen, offer or administer a pneumonia immunization to R2 upon his admission on 3/6/25. (C) 4 of 8 300.1640a) Section 300.1640 - Labeling and Storage of Medications a) All medications for all residents shall be properly labeled and stored at, or near, the nurses' station, in a locked cabinet, a locked medication room, or one or more locked mobile medication carts of satisfactory design for such storage. (See subsections (f) and (g) of this Section.) These requirements were not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure medications were stored in a locked medication cart for twenty-five residents (R2, R9- R31 and R40) of twenty-five residents, reviewed for medication storage, in a sample of 80. Findings include: The facility policy, Pharmacy, dated (revised) 06/2025 directs staff the nurse's station shall have all necessary equipment for proper administration of medications, and current standards of practice should be followed.	S9999					

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S9999	Continued from page 5 On 3/9/26 at 11:02 A.M., V27/Licensed Practical Nurse (LPN) prepared to administer medications for R16. V27/LPN removed one tablet of Gabapentin 300 MG (milligrams) from a pre-packaged container, placed the pill in a plastic medication cup, partially pushed the lock on the facility C- wing medication and walked into (R16)'s room. Leaving the medication cart unlocked and unattended. At 11:04 A.M., V27/LPN returned to the medication cart and pulled the lock open with her fingers. V27/LPN then administered medications for R12, R13, R21 and R25. Each time leaving the medication cart unlocked, and unattended for a period of 6- 7 minutes. At 11:30 A.M., V27/LPN confirmed when lock is only partially pushed in, the medication cart is unlocked and accessible to any resident walking by. On 3/10/26 at 11:58 A.M., V2/Director of Nurses stated the facility medication carts were to be locked whenever a nurse walked away from the cart. (C) 5 of 8 300.2100 Section 300.2100 - Food Handling Sanitation Every facility shall comply with the Department's rules entitled "Food Service Sanitation" (77 Ill. Adm. Code 750). (Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989) These requirements were not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure all food items were labeled and dated and failed to ensure the facility dish machine was working properly at the required sanitizing temperature and sanitizing concentration. This failure has the potential to affect all 88 residents currently residing in the facility. Findings include: The (undated) facility policy, Food Storage, documents that food shall be stored at appropriate temperatures and using appropriate methods to ensure the highest level of food safety. All food items will be stored in covered, labeled and dated containers in the (facility) refrigerators. The (undated) facility policy, Kitchen Sanitation, documents that food prepared in the facility is done so in a safe and sanitary manner.			S9999			

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S9999	Continued from page 6 On 3/9/26 at 9:43 A.M., an observation of the facility kitchen's, Walk in Refrigerator, with V10/Cook present, contained an opened, undated soft drink in a plastic bottle. A second facility Walk in Refrigerator contained a 40 ounce, opened, undated package of Fully Cooked Smoked Turkey Breast cold cut meat with over half of the package missing. On this same date, an observation of the facility Milk Refrigerator contained an opened, undated, partially consumed plastic bottle of coconut water. The facility Dish Machine Temperature Record, documented March 2026 and provided by V10/Cook on 3/9/26 at 10:10 A.M., documents that no required dish machine temperatures and sanitation levels were completed or documented on March 8, 2026, for the morning, noon or evening meal nor on March 9, 2026, for the morning meal. On 3/10/26 at 10:45 A.M., V3/Dietary Manager stated all items in the kitchen refrigerators needed identification and dated when opened. At that time, V3 also stated dietary staff were to check and record the facility dish machine wash temperature and chlorine levels at each meal. The facility Roster dated 3/9/2026 and verified by V1/Administrator, documents 88 residents currently reside in the facility. (C) 6 of 8 300.2210b)1)4) Section 300.2210 Maintenance b) Each facility shall: 1) Maintain the building in good repair, safe and free of the following: cracks in floors, walls, or ceilings; peeling wallpaper or paint; warped or loose boards; warped, broken, loose, or cracked floor covering, such as tile or linoleum; loose handrails or railings; loose or broken windowpanes; and any other similar hazards. 4) Maintain the interior and exterior finishes of the building as needed to keep it attractive and clean and safe (painting, washing, and other types of maintenance). This REQUIREMENT is not met as evidenced by:	S9999					

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S9999	Continued from page 7 Based on observation, interview, and record review the facility failed to ensure the floors and walls in resident rooms were in good repair for four of four residents (R5-R8) reviewed for environment in the sample of 80. Findings include: The facility's Maintenance Director Job Description (undated) documents, "Responsible for supervising and coordinating the activities of the maintenance department to ensure environmental center compliance in accordance of Federal, State, and Local ordinances, regulations and building codes. Ensures center is maintained in a sanitary, attractive, and orderly condition, in good repair, free from hazards such as those caused by electrical, plumbing, ventilation, heating, and cooling systems." On 3/9/26 at 9:50 AM R6 and R7's wall completely surrounding the wall heating/air conditioning unit had exposed, patched drywall. The cove base between the wall heating/air conditioning unit and the bathroom door was missing. All walls in R6 and R7's room had multiple areas of chipped paint. On 3/9/26 at 9:55 AM R5's wall next to the bathroom door had an approximate one and a half long area of missing cove base and a softball sized area of missing drywall. All walls in R5's room had multiple areas of chipped paint. On 3/9/26 at 10:00 AM R8's room had four missing floor tiles. On 3/9/26 at 10:30 AM R5 verified her walls have missing paint and she would like them painted. On 3/9/26 at 12:00 PM R6 stated she would like to have her walls fixed and painted. On 3/10/26 at 9:53 AM V14 (Housekeeper) stated "(R5, R6, and R7's) walls have needed repaired since I have been here for at least eight months, and (R8's) floor tiles have always been missing." On 3/10/26 at 11:30 AM V16 (Maintenance Director) verified R5, R6, and R7's walls have multiple areas of exposed, patched drywall, missing drywall, missing cove base, and scattered areas of missing paint to the walls and R8's room has missing floor tiles. V16 stated, "I just have not had time to get (R5-R8's) rooms fixed or remodeled yet." (B)	S9999					

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S9999	Continued from page 8 7 of 8 300.3240a) 300.3240b) 300.3240c) 300.3240e) 300.3240g) 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) b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the Department and to the facility administrator. (Section 3-610(a) of the Act) c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative and to the Department. (Section 3-610(a) of the Act) e) 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). g) A facility shall comply with all requirements for reporting abuse and neglect pursuant to the Abused and Neglected Long Term Care Facility Residents Reporting Act. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to prevent resident-to-resident physical and verbal abuse, failed to investigate resident-to-resident physical and verbal abuse, and failed to report resident-to-resident physical and verbal abuse to the State Agency and residents' representatives for three of three residents (R4, R5, and R9) reviewed for abuse in the sample of 80.	S9999					

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S9999	Continued from page 9 Findings include: The facility's Abuse, Prevention, and Prohibition Policy dated 11/25 documents, "Each resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. The facility prohibits mistreatment, neglect, or abuse of residents. The residents must not be subjected to abuse by anyone. Verbal abuse is defined as the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to resident or their families, or within the hearing distance, regardless of their age, ability to comprehend, or disability. Physical abuse includes, but is not limited to, hitting, slapping, punching, biting, and kicking. Investigation: The facility Administrator will ensure a thorough investigation of alleged violations of individual rights and document appropriate action. Reporting/Response: The person made aware of allegations of abuse or neglect, or the Administrator will report the allegations of abuse and neglect to the mandated state agency no later than two hour, or per state regulation, after the allegation is made." R4's Admission Record documents R4 is a 64-year-old admitted to the facility on 5/27/21 with the diagnoses of Schizoaffective Disorder, Major Depressive Disorder, and Bipolar Disorder. R4's MDS (Minimum Data Set) Assessment dated 12/5/25 documents R4 is cognitively intact and has verbal and other behavioral symptoms at least one to three days weekly. R4's current Care Plan documents R4 has behavioral problems of verbal and physical aggression related to Schizoaffective Disorder, Bipolar Disorder, and Major Depressive Disorder. R5's MDS dated 1/23/26 documents R5 is cognitively intact and has verbal behaviors one to three days per week. R5's current Care Plan documents R5 has behaviors of name calling, disruptive behaviors, and verbal aggression towards staff and peers related to Schizoaffective Disorder, Bipolar disorder, Generalized Anxiety Disorder, Depression, Nightmare Disorder, and Intellectual Disabilities.			S9999			

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S9999	Continued from page 10 The facility's Abuse Investigations dated 1/1/26 through 3/9/26 do not include any abuse investigations regarding R4 and R5, or R5 and R9. R5's Progress Notes dated 3/3/26 at 9:00 PM and signed by V23 (RN/Registered Nurse) documents, "(R5) was sitting in the lobby. (R5's) mood is fluctuating. One moment (R5) appears happy and the other minute yelling and cursing everybody that pass by (R5). (R5) got into another resident's (R9's) conversation. (R9) got upset and threw (R9's) drink on (R5). Both (R5 and R9) were separated. Abuse Coordinator (V1/Administrator) and (V2/Director of Nursing) informed about the situation." On 3/9/26 at 11:15 PM R5 was sitting in a chair in the front lobby. R4 was self-propelling in a wheelchair. R5 started yelling at R4, "You ran over my foot you son-of-a-bi**h!" R4 started yelling back at R5, "Go to he*I bi**h! Go to bed stupid bi**h! V1 (Administrator) was standing in the doorway of the front lobby area and stated to (R5), "Settle down." R4 kept self-propelling his wheelchair through the front lobby and continued to yell at R5, "Stupid bi**h! Nj**er bi**h! F*ck you!" On 3/9/26 at 11:30 AM R4 was sitting in a wheelchair in the dining room. R4 refused to talk to this surveyor. On 3/9/26 at 12:15 PM R5 was lying in bed in her room. R5 refused her lunch tray. R5 stated, "I am tired of getting yelled at!" On 3/10/26 at 1:10 PM R9 was lying in bed in his room, reading a book. R9 stated, "I did throw water on (R5) when we were in the lobby (on 3/3/26). (R5) is always having disagreements with me and has really been pi*s*y lately and always cussing me out. (R5) has had a lot of behaviors lately. It didn't help (R5's) behaviors when I threw water on (R5)." On 3/10/26 at 9:00 AM V1 (Administrator) verified he did not investigate or report the verbal abuse altercations V1 witnessed between R4 and R5 that occurred on 3/9/26 at 11:15 AM to the State Agency or residents' representatives and did not investigate or report the verbal and physical abuse altercation that occurred between R5 and R9 on 3/3/26 to the State Agency. On 3/10/26 at 10:40 AM V22 (Social Service Assistant) stated, "If (R4 and R5) were cursing at each other that is verbal abuse." On 3/10/26 at 11:38 AM V24 (Licensed Professional	S9999					

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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) COMPLETION DATE
S9999	Continued from page 11 Clinical Counselor) verified yelling and cursing at each other is considered verbal abuse even if the resident has mental illness. (B) 8 of 8 300.3260f) Section 300.3260 - Resident's Funds f) The facility shall purchase a surety bond or otherwise provide assurance satisfactory to the Departments of Public Health and Insurance that all residents' personal funds deposited with the facility are secure against loss, theft, and insolvency. (Section 2-201(5) of the Act) 1) If a surety bond is secured, it must be issued by a company licensed to do business in Illinois, the amount of bond must be equal to or greater than all resident funds managed by the facility, and the obligee named in the bond must be the Illinois Department of Public Health or its assignees. These requirements were not met as evidenced by: Based on observation, interview, and record review, the facility failed to purchase a surety bond that was equal or greater than the current facility Resident Trust Fund account balance, for seventy-one residents (R3- R10, R13, R16- R29, R31- R79), reviewed for resident accounts, in a sample of 80. Findings include: The facility policy, Resident Trust Fund Policy, provided by V1/Administrator on 3/10/26 directs staff, "It will be the policy of the management company that the (Facility) Resident Trust Fund is managed and accounted for in accordance with State and Federal regulations. The facility shall purchase and maintain a surety bond that will protect resident personal funds against loss, theft and insolvency. The surety bond must be greater than all funds managed by the facility and adheres to State and Federal guidelines." The Facility Surety Bond, dated December 17, 2025, provided by V1/Administrator and V13/Business Office Manager, on 3/9/2026 documents a facility Surety Bond in the amount of one hundred fifty thousand dollars. The facility Trust Fund- Current Account Balance form as of 3/9/26 and provided by V13/Business			S9999			

Illinois Department of Public Health

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S9999	Continued from page 12 Office Manager documents a resident account summary balance of two hundred nine thousand two hundred twelve dollars and sixty-eight cents. On 3/9/26 at 9:57 A.M., V13/Business Office Manager verified the current facility Surety Bond amount and the current facility Trust Fund account balance. At that time V13 stated the company was actively trying to manage the account and that the company was aware that the current Surety Bond did not cover the resident account balance. (B)		S9999				