STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676375	A. Building B. Wing	09/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Giles Nursing and Rehabilitation Center	950 Camino Del Rey Drive El Paso, TX 79927

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45217 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan that included measurable objectives and time frames to meet a resident's medical and nursing needs and described the services to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 (Resident #9) of 6 residents reviewed for care plans -The facility failed to follow the comprehensive person-centered care plan for Resident #9's fall risk, by failing to have a fall mat in place next to bed while resident was lying down in bed. This deficient practice could place residents in the facility at risk of of injury. Findings include: Review of Resident #9's Admission Record dated 09/03/2024, revealed a [AGE] year-old female with an admitted [DATE]. Resident #9's diagnoses included: dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), muscle weakness, abnormalities of gait and mobility, and repeated falls. Review of Resident #9's quarterly MDS assessment dated [DATE], revealed a BIMS score of 03 indicating severe cognitive impairment. Section GG on Functional Abilities and Goals revealed resident requires partial/moderate assistance with transfers. Section J - Health Conditions revealed resident has had falls since admission of 2 or more without any injury. Review of Resident #9's comprehensive care plan dated 09/03/2024, revealed the resident was at risk for falls related to gait/balance problems, history of frequent falls, and lack of coordination. Part of the interventions included Floor mats in place at all times when in bed. Review of Resident #9's Progress Notes dated 08/27/2024 at 9:45 a.m., reads in part Resident #9 heard calling for assistance. Upon entering room resident found sitting on floor between wheelchair and bed. When asked what had happened resident states that she fell trying to get out of bed. Upon assessment no visible injures seen. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676375	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/03/2024
NAME OF PROVIDER OR SUPPLIER St Giles Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 950 Camino Del Rey Drive El Paso, TX 79927	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 09/03/2024 at 1:20 p.m., Resident #9 was in her bedroom lying in bed. Resident #9 had one side of the bed positioned against the wall. On the other side of the bed there was no floor mat next to the bed. Floor mat was leaning upward against Resident #9's dresser drawers approximately 5 feet away from Resident #9. Resident #9 had her eyes closed and appeared to be asleep at the time. During an observation and interview on 09/03/2024 at 1:24 p.m., CNA M entered Resident #9's bedroom and observed the floor mat leaning against the dresser drawers away from Resident #9's side of the bed. CNA M said Resident #9 required a floor mat be in place next to the bed anytime Resident #9 was in bed. CNA M said Resident #9 returned from lunch sometime around 1:00 p.m. and placed in bed by CNA O . CNA M said Resident #9 had history of falls and that the mat was in place to minimize risk of injuries. During an interview on 09/03/2024 at 1:27 p.m., Resident #9 said she felt safe. Resident #9 said she did not remember the last time she had a fall. Resident #9 said she did not know about her fall prevention plan During an interview on 09/03/2024 at 1:30 p.m., LVN L said Resident #9 was a fall risk. LVN L said part of Resident #9's care plan focused on falls and Resident #9 was to have a floor mat next to her bed anytime she was in bed. LVN L said if the floor mat was not in place, this would increase the risk of severity of the injury should a fall from the bed occur. During an interview on 09/03/2024 at 1:47 p.m., the DON said the purpose of a care plan was to provide appropriate care for the residents. The DON said the risk of not following the care plan for a resident with a fall risk was possible severity of injury. The DON said Resident #9 had history of falls and her care plan reflects interventions that should be put in place to address the risk to include the use of a fall mat when she was in bed. The DON said all floor staff to include CNAs and nurses are responsible for following the care plan. During an interview on 09/03/2024 at 2:44 p.m., the Administrator said the purpose of a resident care plan was to give direction on the care that the patient should be receiving. The Administrator said the risk of care plan not being followed means that appropriate care was not being provided and possible serious injury. The Administrator said all floor staff are responsible to ensure the care plan was being followed including ensuring that fall prevention interventions were in place. Review of facility-provided Comprehensive Care Planning policy undated, reads in part Each resident will have a person-centered comprehensive care plan developed and implemented to meet his/her preferences and goals, and address the resident's medical, physical, mental, and psychosocial needs. The comprehensive care plan will reflect interventions to enable each resident to meet his/her objectives. Interventions are the specific care and service es that will be implemented.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45217 Based on interview and record review the facility failed to ensure medical records, in accordance with accepted professional standards and practices, were maintained on each resident that were accurately documented for 1 (Resident #1) of 9 residents reviewed for medical records. -The facility failed to ensure the correct method of transfer was documented in the care plan of Resident #1. This failure could lead to errors in treatment and services provided based on incorrect information. Findings included: Review of Resident #1's Admission Record printed 08/29/2024, revealed an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1's diagnoses included dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), muscle weakness, abnormalities of gait and mobility, and history of falls. Review of Resident #1's quarterly MDS dated [DATE], revealed a BIMS score of 03 indicating severe cognitive impairment. Section GG on Functional Abilities and Goals revealed resident requires partial/moderate assistance with transfers. Section J - Health Conditions revealed resident had not had any falls since admission/entry or reentry or the prior assessment. Review of Occupational Therapy OT Evaluation and Plan of Treatment dated 08/13/2024, revealed resident baseline for commode transfer with moderate assistance 50%. Review of Physical Therapy PT Evaluation and Plan of Treatment dated 08/15/2024, revealed resident baseline for safely performing functional transfers at moderate assistance 50%. Review of Resident #1's Care Plan printed on 08/29/2024, reads in part, Resident #1 was at risk for falls related to balance problems. Part of the interventions reads Hoyer left x2 staff at all times for transfers. During an interview on 08/29/2024 at 4:18 p.m., Resident #1 said she had not been transferred using a mechanical lift for some time and that staff members are the ones to help her transfer. Resident #1 said she did not know her specific transfer instructions. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/30/2024 at 10:33 a.m., the Director of Therapy Services said she was familiar with Resident #1. The Director of Therapy Services said Resident #1 was receiving PT and OT services. The Director of Therapy Services said PT evaluated Resident #1 on 08/15/2024 and she was a moderate assist transfer meaning she could weight bear with moderate assistance. The Director of Therapy Services said one-person assist transfer was acceptable method of transfer for Resident #1. The Director of Therapy Services said a few years ago, Resident #1 had a fracture to the ankle, and it would have made her a mechanical lift transfer at the time. The Director of Therapy Services said following the healing of the fracture, Resident #1 was able to bear weight and had not been mechanical lift transfer in a real long time. The Director of Therapy Services said Resident #1's transfer instructions on the Care Plan noting the need to have a mechanical lift transfer were not correct. The Director of Therapy Services said that she was not aware that those instructions were still included on Resident #1's care plan. During an interview on 09/03/2024 at 1:47 p.m., the DON said that CNAs able to transfer Resident #1 from the wheelchair to the shower chair and vice versa using moderate assistance. The DON said approximately two years ago Resident #1 had an ankle fracture and she was made a mechanical transfer while healing. The DON said therapy services evaluated Resident #1 and her transfer was assessed from minimum to moderate assistance. The DON said the care plan records were not updated to reflect her correct transfer method. The DON said that it is extremely important that documentation including the care plan are accurate because that was how staff know how to care for the residents. The DON said the risk of care plan not being accurate was a patient safety issue by not properly caring for residents and providing appropriate services. During an interview on 09/03/2024 at 2:44 p.m., the Administrator said the purpose of a resident care plan was to give direction on the care that residents should be receiving. The Administrator said she reviewed Resident #1's care plan and found that the plan was not correct. The Administrator said she verified with the Director of Therapy Services and learned that after evaluation Resident #1 was to receive one-person moderate assistance during transfers. The Administrator said the care plan was not updated correctly and was not accurate. The Administrator said in 2022 Resident #1 had a fracture to the right leg and she was a mechanical lift transfer until she healed. The Administrator said unfortunately there had been several staff changes with the MDS department and Resident 1's care plan was not updated to reflect her accurate transfer instructions. The Administrator said she has started an audit on all care plans to identify if there were any other inaccurate information. The Administrator said the risk of care plans not being accurate could result in confusion in the direction of care for the resident. Review of facility-provided Documentation policy dated 2003, reads in part, Documentation is the recording of all information, both objective and subjective, in the clinical record of an individual resident. It has legal requirements regarding accuracy and completeness, legibility and timing .clinical record are utilized in nursing documentation such as care plans . The facility will maintain complete and accurate documentation for each resident on all appropriate clinical record sheets.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45217 Based on observation, interview, and record review, the facility failed to ensure each resident received adequate supervision and that the resident environment remained as free of accident hazards as possible for 2 (100 hall and 200/300 hall shower rooms) out of 3 shower rooms and 1 of 6 residents (Resident #9) reviewed for accidents and supervision. - The facility failed to ensure that razor blades were disposed of properly in the sharp container in two (100 hall and 200/300 hall shower rooms) of three shower rooms. - The facility failed to place fall mat on floor next to Resident #9's bed when she was in bed These failures could place residents at risk for injuries. Findings included: During an observation on 08/29/2024 at 11:23 a.m., three disposable shaving razors were noted outside of a sharp's container in a shower room in between 300 and 400 halls. During an observation on 8/30/2024 at 3:30 p.m., three disposable shaving razors were noted outside of the sharp's container in a shower room in the 100-hall. During an interview on 08/30/2024 at 3:38 p.m., the DON was shown a picture of the overflowing sharps container from the 100-hall shower room. The DON said leaving disposable shaving razors outside of the sharp's container was not acceptable. The DON said risks include residents or staff can obtain razors and cut selves. The DON said that central supply should be emptying the containers and would have the containers emptied immediately. During an interview on 09/03/2024 at 1:47 p.m., the DON said there had been no injuries from residents or staff getting items from sharps container. The DON said there were three showers in the facility. The DON said there was always a staff member to accompany a resident into the shower room. The DON said only 3 or 4 residents do not use the shower room and receive bed baths. The DON said no resident goes by themselves into the shower room. The DON said the doors into the shower rooms read Employees Only. The DON said still there was still a risk that residents inside of the shower room could get a hold of razors that were not properly disposed of. The DON said the purpose of the sharp's container was to ensure that needles and razors out of reach of residents or other staff members. The DON said the risk of not properly disposing sharps was possibly resident or staff cutting themselves, injury and possible infection. During an interview on 09/03/2024 at 2:44 p.m., the Administrator said the purpose of the sharp's containers in the shower rooms was for sharp objects to be disposed of safely. The Administrator said the facility had not had any injuries associated with anyone getting any sharp objects that were not disposed of correctly. The Administrator said that the risk of sharps not being properly disposed was a staff member or potentially a resident cutting themselves. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility-provided Discarding of Sharps policy dated 2003, reads in part, Purpose to minimize the risk of injuries related to handling of sharps and the risk of transmission of blood-borne diseases. Sharps will be placed intact into sharps containers immediately after use. Sharps include: any other disposable equipment, which potentially could puncture the skin during normal use, such as disposable razors, etc. Review of Resident #9's Admission Record dated 09/03/2024, revealed a [AGE] year-old female with an admitted [DATE]. Resident #9's diagnoses included: dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), muscle weakness, abnormalities of gait and mobility, and repeated falls. Review of Resident #9's quarterly MDS assessment dated [DATE], revealed a BIMS score of 03 indicating severe cognitive impairment. Section GG on Functional Abilities and Goals revealed resident requires partial/moderate assistance with transfers. Section J - Health Conditions revealed resident has had falls since admission of 2 or more without any injury. Review of Resident #9's comprehensive care plan dated 09/03/2024, revealed the resident was at risk for falls related to gait/balance problems, history of frequent falls, and lack of coordination. Part of the interventions included Floor mats in place at all times when in bed. Review of Resident #9's Progress Notes dated 08/27/2024 at 9:45 a.m., reads in part Resident #9 heard calling for assistance. Upon entering room resident found sitting on floor between wheelchair and bed. When asked what had happened resident states that she fell trying to get out of bed. Upon assessment no visible injures seen. Observation on 09/03/2024 at 1:20 p.m., Resident #9 was in her bedroom lying in bed. Resident #9 had one side of the bed positioned against the wall. On the other side of the bed there was no floor mat next to the bed. Floor mat was leaning upward against Resident #9's dresser drawers approximately 5 feet away from Resident #9. Resident #9 had her eyes closed and appeared to be asleep at the time. During an observation and interview on 09/03/2024 at 1:24 p.m., CNA M entered Resident #9's bedroom and observed the floor mat leaning against the dresser drawers away from Resident #9's side of the bed. CNA M said Resident #9 required a floor mat be in place next to the bed anytime Resident #9 was in bed. CNA M said Resident #9 returned from lunch sometime around 1:00 p.m. and placed in bed by CNA O . CNA M said Resident #9 had history of falls and that the mat was in place to minimize risk of injuries. During an interview on 09/03/2024 at 1:27 p.m., Resident #9 said she felt safe. Resident #9 said she did not remember the last time she had a fall. Resident #9 said she did not know about her fall prevention plan During an interview on 09/03/2024 at 1:30 p.m., LVN L said Resident #9 was a fall risk. LVN L said part of Resident #9's care plan focused on falls and Resident #9 was to have a floor mat next to her bed anytime she was in bed. LVN L said if the floor mat was not in place, this would increase the risk of severity of the injury should a fall from the bed occur. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/03/2024 at 1:47 p.m., the DON said the purpose of a care plan was to provide appropriate care for the residents. The DON said the risk of not following the care plan for a resident with a fall risk was possible severity of injury. The DON said Resident #9 had history of falls and her care plan reflects interventions that should be put in place to address the risk to include the use of a fall mat when she was in bed. The DON said all floor staff to include CNAs and nurses are responsible for following the care plan. During an interview on 09/03/2024 at 2:44 p.m., the Administrator said the purpose of a resident care plan was to give direction on the care that the patient should be receiving. The Administrator said the risk of care plan not being followed means that appropriate care was not being provided and possible serious injury. The Administrator said all floor staff are responsible to ensure the care plan was being followed including ensuring that fall prevention interventions were in place.