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	11/25/2024

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 #1) of 6 residents reviewed for care plans. -The facility failed to develop a comprehensive person-centered care plan for Resident #1 regarding significant change of condition of a newly diagnosed DVT (a blood clot in a deep vein in the body). -The facility failed to develop a comprehensive person-centered care plan for Resident #1's severe weight loss. This deficient practice could place residents in the facility at risk of not receiving the necessary care or services as indicated in their comprehensive person-centered plans to meet their needs for care assistance and treatments. Findings include: Record review of Resident #1's Admission Record dated 11/20/2024, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Admitting diagnoses included dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), morbid obesity (chronic disease in which a person has a body mass index of 40 or higher and is experiencing obesity-related health conditions), catatonic schizophrenia (rare severe mental disorder characterized by striking motor behavior, typically involving either significant reductions in voluntary movement or hyperactivity and agitated), major depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), mild intellectual disabilities (deficits in theoretical thinking/learning), and post cholecystectomy syndrome (a progressive brain disease that causes a decline in thinking abilities). (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's quarterly MDS dated [DATE], revealed Section C - Cognitive Patterns, that the resident was rarely/never understood. Section GG - Functional Abilities, revealed resident was dependent for toileting hygiene, showering/bathing, dressing, bed mobility, and transfers, and substantial/maximal assistance with eating, oral and personal hygiene. Section K - Swallowing/Nutritional Status, revealed Resident #1 had a loss of 5% or more in the last month or loss of 10% or more in the last 6 months and was not on a physician-prescribed weight-loss regimen. Resident #1 had a mechanically altered diet and therapeutic diet. Section N - Medications, revealed resident was taking an anticoagulant. Review of Resident #1's weight records from 5/1/2024 to 11/4/2024 revealed the following: -one-month review, Resident #1 had a 7.4% weight loss -three-month review, Resident #1 had a 14.4% weight loss -six-month review, Resident #1 had a 17.6% weight loss. Record review of Resident #1's progress notes dated 11/02/2024 at 1:01 p.m., revealed the physician ordered Resident #1 receive a venous doppler (special ultrasound technique that evaluates blood as it flows through a blood vessel including major arteries, and veins in the abdomen, arms, legs, and neck), to the right upper extremity to rule out DVT. Record review of Resident #1's progress notes dated 11/02/2024 at 9:46 p.m., revealed results of the venous doppler were received and found to be positive. Findings were reported to the provider on call and new order for Xarelto 20 mg for three months was received. Record review of Resident #1's order summary dated 11/18/2024, revealed the resident was on a pureed texture diet with regular consistency, for difficulty with mechanical soft texture diet. The order summary further revealed an order with start date of 11/03/2024, for Xarelto Oral Tablet 20 mg, to be taking one time a day for DVT for 3 months. Review of Resident #1's MAR for month of November 2024, revealed resident was taking her medications as ordered. Record review of Resident #1's Care Plan dated 11/20/2024, revealed no care plan information related to DVT care. Further review revealed the following focus area initiated on 4/16/24: Resident #1 had a diet order other than regular and was at risk for unplanned weight loss or gain. There was no care plan for Resident #1's severe weight loss. During an observation and interview on 11/20/2024 at 3:40 p.m., revealed Resident #1 was at the hospital and the resident was noted to be sedated and intubated. The hospital nurse stated when the resident arrived at the hospital ER, the resident became unresponsive and hypoxic (having too little oxygen) and was intubated. The hospital nurse said Resident #1 was still being treated for a DVT to her right arm with no concerns regarding treatment for DVT. The hospital nurse said there were no concerns regarding Resident #1 having any weight loss. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/20/2024 at 11:44 a.m., LVN I said Resident #1 was fully dependent on staff for all ADL's. LVN I said Resident #1 was not able to move much and was verbally incomprehensible. LVN I said during a physician visit to the facility, Resident #1 was seen for possible dependent edema (fluid builds up in the body's tissues, causing swelling) of her right arm. On 11/2/2024 Resident #1 was found to have a DVT to her right arm and the physician ordered medication Xarelto to treat the DVT. LVN I reviewed Resident #1's care plan and said that the DVT was not care planned. LVN I said he did not know why a care plan was not developed for the DVT care. LVN I said that the physician was aware and treating the DVT. LVN I said Resident #1 was being monitored while on her treatment. LVN I said Resident #1 started eating less in the past few weeks and less despite staff and family encouraging her and being present to offer feeding assistance. LVN I said CNAs would report how much Resident #1 would eat, and then LVN would ensure Resident #1 was given a supplemental shakes. LVN I said there was no care plan regarding any severe weight loss. During an interview on 11/22/2024 at 10:06 a.m., the DON said while the PCP was rounding at the facility, swelling to Resident #1's right arm was reported. The DON said an ultrasound was ordered and Resident #1 found to have a DVT. The DON said the DVT should have been care planned immediately after the diagnosis. The DON said the ADON should have care planned the DVT care. The DON said the DM was the person who monitored resident weights. The DON said weights were discussed during the facility weekly standard of care meeting. The DON said she could not remember Resident #1 being discussed during the meetings. The DON said severe weight loss should have been care planned but was not. The DON said if the DM reported severe weight loss of Resident #1, then the ADON should have developed a care plan. The DON again said she did not remember if the DM ever informed the DON or ADON of any weight loss by Resident #1. During an interview on 11/22/2024 at 11:17 a.m., the ADON said Resident #1 could not eat on her own and required assisted feeding. The ADON said Resident #1 was diagnosed with DVT and that was a change of condition. The ADON said the change in condition DVT should have been care planned. The ADON said the MDS staff and nursing staff developed the care plans. The ADON said she should have care planned the DVT but had been very busy with a lot of staff turnover at the facility. The ADON said the Dietary Manager was responsible for having resident weights done and reviewed. The ADON said the Dietary Manager would have been responsible to report changes such as significant gain or losses to the team and the Dietitian. The ADON said she did not recall any meeting discussion regarding Resident #1's weight loss. The ADON said Resident #1 was being given supplement shakes when she would not eat her meals. The ADON said there was no care plan for her severe weight loss other than she was at risk of unplanned weight loss. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/22/2024 at 11:48 a.m., the Dietary Manager (DM) said the last time he worked at the facility was 11/8/2024 and had been out due to injury. The DM said he monitored the weights of residents. The DM said he was familiar with Resident #1. The DM said Resident #1's ate at the assisted table because she could not eat on her own. The DM said her dementia was progressing and she was usually eating 50% to 75% of her meal. The DM said he knew Resident #1's weight was decreasing slowly but not so fast. The DM said she was not on a planned weight loss. The DM said in November 2024, he communicated via email that Resident #1 had experienced 5% or more weight loss and would start with weekly weights. The DM said the email was sent to the Dietitian, DON, ADON and Administrator. The DM said he was involved with an accident outside of the facility on 11/8/2024 and had not returned to work. The DM said he believed the ADONs were monitoring the weights. The DM said he had not reported any severe weight loss prior to November 2024. The DM said he was responsible for reporting any severe weight changes to the team that included the DON and ADONs. The DM said the severe weight loss should have been care planned but that was a nursing department and MDS function. During an interview on 11/22/2024 at 12:54 p.m., the Dietitian said that the PCP had noted that Resident #1 would benefit from weight loss. The Dietitian said the physician also noted being aware that the resident had been eating poorly which had started prior to the resident being admitted to the facility. The Dietitian said she was not aware of the severe weight loss by the DON, ADON, or the Dietary Manager. During an interview on 11/25/2024 at 12:02 p.m., the PCP said he was aware of Resident #1's weight loss and that her weight loss was beneficial for her. The PCP said Resident #1's weight loss was occurring due to disease process, and nothing could be done as the family refused to consider a G-tube for the resident. The PCP said the resident was not eating or drinking by the time she was sent to the hospital and due to advanced condition, her health was steadily declining. The PCP said he was aware that Resident #1 had a DVT to her right arm and was treating the DVT with medication. The PCP said he was not aware if the DVT, and weight loss were being care planned at the facility. The PCP said he visited the facility weekly and did not have any concerns with care and services Resident #1 received. During an interview on 11/25/2024 at 2:36 p.m., the Administrator said resident weight loss should be monitored and severe weight loss should be care planned. The Administrator said the Dietary Manager sent an email on 11/5/2024 saying that Resident #1 should have been weighed weekly but there was not follow-up documentation. The Administrator said the purpose of a care plan was to make sure the facility staff was following what they were supposed to be doing and providing the care needed by the residents. The Administrator said nursing should have been responsible for including the changes in condition in the care plan. Review of facility provided Notifying the Physician of Change in Status policy dated 03/11/2013, reflected in part if the resident remains in the facility and a significant change has occurred, update the care plan accordingly. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility provided Comprehensive Care Planning policy undated, reflected 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 services that will be implemented. The resident's care plan will be reviewed after each Admission, Quarterly, Annual and/or Significant Change MDS assessment, and revised based on changing goals, preferences and needs of the resident and in response to current interventions.