

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 02/26/2026
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	
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)		
<p>F 0551</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give the resident's representative the ability to exercise the resident's rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, that facility failed to extend to the resident representative 's the right to make decisions on behalf of the resident for 1 of 6 (Resident #1) residents reviewed for resident rights in that: The facility failed to establish who Resident #1 wanted as a responsible party during his stay at the Nursing Facility. This failure could place residents at risk of not having their preferred responsible party represent them in care decisions. Findings include: Record review of Resident #1's face sheet dated 02/26/2026 revealed a [AGE] year-old male who was admitted on [DATE] and listed family member #2 as the responsible party. Record review of Resident #1's history and physical note dated 02/05/2026 revealed a diagnosis of terminal diagnosis of senile degeneration of the brain (final stage of severe age-related brain disease). The note revealed that Resident #1 was alert and oriented to person, place and situation but demonstrated significant forgetfulness and impaired insight. Record review of Resident #1's entry MDS dated [DATE] revealed no BIMS score. Record review of Resident #1's BIMS assessment dated [DATE] revealed a BIMS score of 08 indicating moderate cognitive impairment. Record review of Resident #1's orders revealed an order for DNR/Hospice care initiated on 02/06/2026. Record review of Resident #1's hospice paperwork dated 02/06/2026 revealed the resident was placed under hospice care on 02/06/26, and was signed by Family Member #2. Record review of Resident #1's PASRR Level Screening dated 02/04/2026 revealed a next of kin listed a family member #3. In an interview on 02/24/2026 at 10:21am with Resident #1's Family Member #3 revealed that Resident #1 was placed on hospice by family member #2 prior to transferring to long-term care facility from a local hospital. She stated that she was notified after the fact. She stated that at the current facility, Resident #1 was stating to the facility that he did not want Family Member #2 to be his responsible party because she did not treat him well. She stated that Resident #1 did not have the power of attorney. She stated that the current facility did not consult with the family members or the resident concerning who he wanted as a representative. She stated that the facility just kept the same responsible party as the hospital because Resident #1 lived with Family Member #2 prior to entering the long-term care facility. She stated that she did not want Resident #1 under hospice because she believed that he did not need it, she stated that Family Member #2 had him placed under hospice because at the time they were told that he was dying, but he got better but Family Member #2 still kept him under hospice services. She stated that she voiced to the Nursing Facility that she felt that Resident #1 did not need to be under hospice services during a care plan meeting held on 02/12/2026, however she was told that Resident #1's next of kin was Family Member #2 and that he had come with her designated as next of kin when he was admitted to the Nursing Facility. In an interview on 02/24/2026 at 2:21 pm with the Administrator revealed that Resident #1 was admitted with hospice orders. She stated that the hospice paperwork was signed by the current representative who was Family Member #2. She stated that Resident #1 had the representative appointed when he came into facility. She stated that</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 676375
		If continuation sheet Page 1 of 2

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<p>F 0551</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>she was not aware of PASSR paperwork listing Family Member #3 as next of kin. She stated that she was aware that the resident was voicing not wanting to be in hospice when he arrived to the facility. She stated that the Social worker had requested for a BIMS assessment to be done on the resident to assess cognition, but that it had not been done because resident was on hospice services. She stated the representatives were determined by the family; it would be a family conversation on who the representative/ power of attorney would be. She stated that the facility relied on the information on the hospice paperwork and the facility did not look further into who the next of kin was or asked the resident who he wanted as a representative. She stated that when the facility spoke to the hospice agency, they had mentioned that the representative was Family Member #2 and that Family Member #2 was also stating that she was the representative. She stated that the facility usually followed whoever was listed as the next of kin to serve as the representative. She stated that the risk of not verifying who the correct next of kin or representative was would be miscommunication in resident care and a possible delay in care as well. In an interview on 02/24/2026 at 3:00 pm with the Social Worker revealed that she was not aware that Resident #1 had a next of kin. She stated that once a resident was admitted to the facility, she looked at the system to inform herself about who the guardian/power of attorney/representative was. She stated that in this case, in the system, F family Mmember #2 was listed as the responsible party. She stated that in her interactions with Resident #1, she noticed that he was alert and oriented to person, place and situation. She stated that she requested a BIMS assessment to be done to better gauge his cognition. She stated that the therapy department was the ones to perform the assessment and at the time, therapy stated that since Resident #1 was under hospice care, they could not perform the BIMS assessment, therefore, the resident did not have a BIMS assessment done. She stated that the resident was admitted with an open APS case involving family dynamics. She stated that she was aware of some family dynamic issues within the family, but that ultimately the case was closed. She stated that a risk of not ensuring the right responsible party or next of kin was assigned would be a miscommunication of resident's care. In an interview on 02/26/2026 at with Resident #1 revealed that he did not know how he ended up at the facility under hospice. He stated that Family Member #2 left him there because she did not want him back home. He stated that he did not want to be under hospice services and that he wanted Family Member #3 as his responsible party to be able to make decisions on his behalf. He stated that the Nursing Facility never asked him who he wanted as a responsible party when he arrived to the facility. Review of facility policy and procedure titled Resident Rights, undated, read in part the resident has the right to identify individuals or roles to be included in the planning process .</p>		