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	05/08/2026

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on observation, interview and record review the facility failed to maintain evidence demonstrating the result of all grievances for a period no less than 3 years from the issuance of the grievance decision for 1 of 1 grievance binders reviewed.The facility failed to maintain evidence demonstrating the results of grievances from 04/14/26-05/08/26.This failure could place residents at risk of not having their grievances properly resolved, tracked, and documented for future review.Findings include:During an observation and record review on 05/07/2026 at approximately 1:30 PM, revealed that the grievance binder provided did not have any documentation of grievances from 04/14/26-05/08/26. During an interview on 5/8/269 at 111:38 am, the DON stated that any verbal concerns or complaints were reported to the Administrator in accordance with the facility grievance process. The DON stated that she investigated concerns related to the nursing department and reported findings to the Administrator. The DON stated that the Administrator was responsible for overseeing, tracking, and maintaining grievance records. The DON stated that failure to maintain grievance documentation could prevent the facility from demonstrating that concerns had been addressed. During an interview on 5/8/26 at 12:27 pm, The Administrator stated that, based on the facility grievance policy, she was responsible for maintaining grievance records. The Administrator stated the grievance tracking system was missing. The Administrator stated she maintained personal notes regarding concerns; however, she stated she did not maintain the grievance forms necessary to demonstrate how complaints were addressed and tracked. The Administrator stated the SW typically completed grievance tracking; however, due to the absence of an SW, she had been overseeing the process and stated the lack of tracking was an oversight. The Administrator stated a new SW had been hired and stated she waited for the individual to complete a two-week notice period prior to starting employment. Risks identified included the facility's inability to demonstrate complaints were appropriately addressed and tracked due to the absence of a grievance tracking system. Record review of the facility policy titled Grievances dated 11/2/2016 read in part, The grievance official will: Receive and track grievances to their conclusion Maintain the confidentiality of all information associated with grievances.

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

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to follow requirements of their written agreement with hospice agency indicating the facility would immediately notify the hospice about a significant change in the resident's physical, mental, social, or emotional status for 1 resident (Resident #2) of 1 reviewed for hospice care. The facility did not notify the local hospice agency of an as needed care plan meeting for Resident #2's significant change of condition in which Resident #2 was admitted to Hospice on [DATE]. The facility failed to implement a coordinated comprehensive person-centered care plan for Resident #2 when she was admitted to hospice on [DATE] for a significant change in condition. This failure could cause a decline in health for residents in hospice if the hospice agency is not notified of changes to their care plan.Findings included:Record review of Resident #2's Face Sheet dated [DATE], revealed, a [AGE] year-old female who was admitted on [DATE] and re-admitted on [DATE] to the facility. Diagnoses included Type 2 diabetes, Vascular Dementia (decline in thinking, memory, and behavior caused by conditions that block or reduce blood flow to the brain, depriving it of oxygen and nutrients), Unspecified Dementia (a diagnosis used when a patient shows clear signs of cognitive decline (memory loss, reasoning issues) that impair daily life, but tests cannot pinpoint a specific cause, such as Alzheimer's or vascular dementia), Mood Disorder due to known physiological condition with mixed features (describes a mental health state where symptoms of both mania/hypomania and depression occur concurrently, directly caused by a medical condition (e.g., stroke, hormonal disorder) or medication), anxiety disorder, and insomnia. Record review of Resident #2's significant change MDS dated [DATE], revealed, Resident #2's has severely impaired cognition with a BIMS score of 3 and unable to recall or make daily decisions. Resident #2 was coded for disorganized thinking. Record review of Resident #2's care plan dated [DATE], revealed, Resident #2 had a terminal prognosis and/or was receiving hospice services under local hospice. Assess Resident #2's coping strategies and respect Resident #2s wishes. Consult with physician and Social Services to have hospice care for Resident #2 in the facility. If receiving hospice services, work cooperatively with hospice team to ensure the Resident #2's spiritual, emotional, intellectual, physical and social needs are met. Record review of Resident #2's physician order(s) dated [DATE], revealed, admitted under local hospice related to diagnosed heart failure. Order date [DATE], revealed, DNR/Hospice. Interview with Resident #2 was not conducted as resident had already expired. During an interview on [DATE] at 10:11 a.m., with the Hospice Nurse, she stated when Resident #2 was admitted to hospice on [DATE], that she was not asked to attend nor did she attend a care plan meeting regarding Resident #2's significant change. The Hospice Nurse stated it would have benefited if hospice was part of the care plan because they (hospice & the facility) would have known what was going on and know what care was being provided. During an interview on [DATE] at 11:53 a.m., the ADON she stated hospices were involved in care plans. The ADON stated the facility should have had a care plan meeting with the local hospice for Resident #2's significant change in condition on [DATE]. The ADON stated the Receptionist was responsible for calling the local hospice for care plan meetings. The ADON stated she was not sure who was responsible for ensuring that the Receptionist was actually calling the local hospice for the care plan meetings. The ADON stated the negative outcome of not calling the local hospice and/or the local hospice not attending would be that they would not know what would be happening with the resident. During an interview on [DATE] at 1:28 p.m., with the Hospice DON, he stated the local hospice did not have any care plan meetings with the facility for Resident #2 who was admitted into hospice on [DATE]. The Hospice DON stated they were not invited to any care meetings with the facility for Resident #2. The Hospice DON stated it would have benefited Resident 2 because hospice and the facility could have calibrated and talk about how Resident #2 was declining. During an interview on [DATE] at 2:13 p.m., the MDS Nurse stated (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care plan meetings were done quarterly, on request, and as needed. The MDS Nurse stated Resident #2 had a care plan meeting regarding being admitted to hospice on [DATE]. The MDS Nurse stated Resident #2 was on hospice and the focus area of hospice care was updated on her care plan on [DATE]. The MDS Nurse stated the Receptionist was responsible for calling the local hospice. The MDS Nurse stated she was not sure the receptionist actually called the local hospice for the care plan meetings. The MDS Nurse stated the local hospice for Resident #2 had not been attending the care plan meeting(s). The MDS Nurse stated the facility needed the local hospice at the care plan meeting so everyone would be on the same page and know what was going on with Resident #2. The MDS Nurse stated she did not think there would be a negative outcome if the local hospice did not attend the care plan meeting. The MDS Nurse stated as per the facility policy the local hospice needed to be invited so that they may attend the residents care plan meeting.During an interview on [DATE] at 2:42 p.m., the Receptionist stated the MDS Nurse would provide her with a list of residents who she needed to call from hospice for care plan meetings. The Receptionist stated that she would notify the MDS staff via Outlook in real time to inform them of who was going to attend or not. The Receptionist stated she was not able to confirm if she had or had not notified the local hospice for Resident #2 as it did not save in the system. During an interview on [DATE] at 2:55 p.m., with the DON, she stated the purpose of a care plan was to see the residents plan of care and medications and special interventions. The DON stated that local hospice was called to be apart of the care plan meeting. The DON stated it was the responsibility of the Receptionist to call and schedule the care plan meetings with hospice. The DON stated she would not know if it was the SW or MDS who were responsible for overseeing that the local hospice was invited to the care plan meeting. The DON stated the risk would be the local hospice missing out on something that the resident might need The DON stated the local hospice not attending the care plan meeting would not be a coordinated offered to provide the needed services for the resident During an interview on [DATE] at 3:15 p.m., the Administrator stated she would receive an e-mail with resident names and who would be having a care plan meeting from the Receptionist. The Administrator stated the Receptionist calls the local hospice for care plan meetings so they may attend and coordinate with them. The Administrator stated that MDS was ensured the Receptionist was making the calls to the local hospice. The Administrator stated that the list was sent in the system in real time and was not saved. The Administrator stated the local hospice should be included in the care plan meetings since the residents were under their services. The Administrator stated the negative impact of not inviting the local hospice was that they would not be aware of the interventions in place for the residents.Record review of the facilities Hospice Services policy not dated, revealed, Procedures - 3. The delineation of the role(s) of the hospice and the nursing facility in the admission process, recipient and family assessment, and the interdisciplinary team case conferences. 12. The nursing facility and hospice provider must ensure that a coordinated plan of care reflects the participation of the hospice.Record review of the facilities Hospice Care Services Agreement dated [DATE], revealed, Agreement - Definitions: Plan of Care - The plan of care must reflect the Hospice patient and family goals and interventions based on the problems identified in the Hospice Patient Assessment. The Plan of Care should reflect the participation of the hospice which include implementing and coordinating the plan of care. Exhibit A - Section I Services: 4. Plan of Care - 4.1. The Plan of Care shall include those services to be provided by the facility and coordinated by the hospice. 4.4. The Plan of Care shall be developed in full consultation of both Hospice and Facility. The parties agree that each shall maintain its portion of the Plan of Care, in accordance with applicable laws and regulations governing each party. Furthermore the parties will collaborate in jointly coordinating the implementation, evaluation and modification, as needed, of the Plan of Care on an ongoing basis.