

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/07/2026
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)		
F 0689 Level of Harm - Actual harm Residents Affected - Few	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** Based on interview, observation, and record review the facility failed to ensure each resident received adequate supervision to prevent accidents for 1 of 5 residents (Resident #3) reviewed for accidents hazards and supervision. -The facility failed on 06/28/2026 to prevent Resident #3 from falling due to CNA C leaving Resident #3 on her right side while attempting to change the draw sheets. This resulted in Resident #3 experiencing severe pain, being transported to the hospital and developing bruising to her left forehead, left eye, and left shoulder. These deficient practices could affect residents by injuring them during transferring and repositioning care. Findings included: Record review of Resident #3's admission sheet dated 07/07/2026 revealed a [AGE] year-old female with an initial admission date of 02/26/2026 and a readmission date 06/29/2026. Record review of Resident #3's Quarterly MDS dated [DATE] revealed the resident had a BIMS of 12 indicating the resident had moderate cognitive impairment. Under section GG - functional abilities, mobility, the resident was coded as not applicable for rolling left to right with the significance being not attempted and the resident did not perform this activity prior to the current illness. The resident was coded as requiring partial to moderate assistance (helper does less than half the effort) for sit to lying and lying to sitting on side of bed. The resident was coded as requiring substantial to maximal assistance(helper does more than half the effort) for sit to stand and chair/bed to chair transfer. Under section H - bladder and bowel the resident was coded for having an ostomy (an opening in the abdominal wall to redirect waste out of the body). Under section I - Active Diagnoses the resident was diagnosed with muscle wasting and atrophy (conditions where the muscle tissue shrinks and weakens), muscle weakness (reduced capacity to exert force with your muscles), age-related osteoporosis without current pathological fracture (progressive bone density loss in older adults). Under section J - health conditions the resident was coded for not having a fall since admission/entry into the facility. Record review of Resident #3's comprehensive care plan dated 05/08/2026 revealed no focus or interventions for assisting the resident with ADLs, transfer, and repositioning. Record review of Resident #3's physical and history dated 02/27/2026 revealed the resident was diagnosed with end-stage renal disease (the final stage of a chronic kidney disease, when kidney function drops to less than 15% of normal capacity), age related physical debility (progressive functional decline, muscle weakness, slow gait, and severe fatigue), and pleural effusion (an abnormal buildup of excess fluid in pleural space between the lungs and chest wall). Record review of CNA C's written statement undated, read in part after Spanish to English translation, I was changing [Resident #3]. She was sitting on the bed and I told her that we would lower the back of the bed so it would be easier and more comfortable for her. The bed still had the bedspread (draw sheet) on and I was taking it off. I stood on the right side of the bed and I turned her to the left side to start removing the bedspread (draw sheet), I adjusted her (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
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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to, in response to allegations of abuse, neglect, exploitation, or mistreatment, have evidence that all alleged violations are thoroughly investigated and report the results of all investigations to the State Survey Agency within 5 working days of the incident for 3 of 3 residents (Residents #1, #2, #3) reviewed for records. -The facility failed on 05/28/2026 to thoroughly investigate a self-reported incident with an allegation of neglect for Resident #1 who was alleged to have been exploited for \$2,000 by a family member.-The facility failed on 07/03/2026 to thoroughly investigate a self-reported incident within 5 working days of it being reported to the stated on 06/27/2026-The facility failed on 07/06/2026 to thoroughly investigate a fall that occurred on 06/28/2026 while CNA C was providing care to Resident #3. These deficient practices could affect residents by failing to prevent further neglect and taking appropriate corrective action based on investigation findings.Findings included: Resident #1 Record review of Resident #1's admission sheet dated 07/07/2026 revealed a [AGE] year-old male with an initial admission date on 02/05/2026. Record review of Resident #1's Quarterly MDS dated [DATE] revealed the resident had a BIMS score of 6 indicating the resident had severe cognitive impairment. Under Section I, active diagnoses, the resident was diagnosed with unspecified dementia, unspecified severity, with other behavioral disturbances (undeniable cognitive decline and behavioral complications without the exact cause being determined) and senile degeneration of brain, not elsewhere classified (progressive age-related cognitive decline or brain tissue shrinkage that occurs without distinct neurological disorders). Record review of Resident #1's care plan dated 07/01/2026 revealed the resident had a focus area for impaired cognitive function/dementia or impaired thought processes with an intervention to communicate with the resident regarding resident's capabilities and needs. Record review of Resident #1's physical and history dated 02/07/2026 reflected he was diagnosed of unspecified dementia, unspecified severity, with other behavioral disturbances (undeniable cognitive decline and behavioral complications without the exact cause being determined) and senile degeneration of brain, not elsewhere classified (progressive age-related cognitive decline or brain tissue shrinkage that occurs without distinct neurological disorders), anxiety disorder (mental health conditions involving excessive fear and worry that interferes with daily life), and required redirection as needed. Under neurological assessment the resident was alert and oriented to self and able to follow simple commands. Resident #2 Record review of Resident #2's admission sheet dated 07/03/2026 revealed a [AGE] year-old female with an initial admission date on 05/04/2026 and readmission date on 06/29/2026. Record review of Resident #2's admission MDS dated [DATE] revealed the resident had a BIMS score of 0 indicating the resident had severe cognitive impairment. Under section GG functional abilities, self-care, revealed the resident was dependent on staff for toileting, bathing, and dressing. Under the mobility portion, the resident was coded for requiring partial to moderate assistance for rolling left to right, sitting to lying, chair to bed and bed to chair transfers. Record review of Resident #2's care plan dated 05/05/2026 revealed the resident had a focus area for impaired cognitive function/dementia or impaired thought processes with an intervention to communicate with the resident regarding resident's capabilities and needs. The resident had a focus area to address the risk for falls related to confusion, gait/balance problems, and unaware of safety. Record review of Resident #2's physical and health dated 05/04/2026 revealed the resident was diagnosed with dementia (a decline in mental ability that interferes with cognitive abilities and to function independently), previously suffered from a fall at home resulting in hospitalization, and (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	physical deconditioning (decline of physiological and functional abilities). Record review of Resident #2's progress notes dated 06/21/2026 by ADON B read in part, Resident had a fall. Location: Resident room. Fall information: unwitnessed, from low bed, discovered on floor, next to bed. Resident found on top of floor mat crawling. Head to toe assessment performed. resident is not receptive to redirection or use of call light. no pain. Resident #2's progress notes reflected neuro assessments were completed 11 times on 06/21/2026 and ongoing monitoring for change of condition, pain, and 1 weekly skin assessment with no findings. Resident #2's progress notes revealed the resident was transferred to the hospital on [DATE] at 12:35 a.m. due to significant findings in the form of a right tibia and fibula (leg bones below the knee and about the ankle) fracture. Record review of the residents x-ray results dated 06/26/2026 at 10:50 p.m. revealed the resident had acute-appearing fractured to the lower portion of her right tibia and fibula along with bone demineralization (signs that the bones are losing their strength and becoming fragile) Resident #3 Record review of Resident #3's admission sheet dated 07/07/2026 revealed a [AGE] year-old female with an initial admission date of 02/26/2026 and a readmission date 06/29/2026. Record review of Resident #3's Quarterly MDS dated [DATE] revealed the resident had a BIMS of 12 indicating the resident had moderate cognitive impairment. Under section GG - functional abilities, mobility, the resident was coded as not applicable for rolling left to right with the significance being not attempted and the resident did not perform this activity prior to the current illness. The resident was coded as requiring partial to moderate assistance for sit to lying and lying to sitting on side of bed. The resident was coded as requiring substantial to maximal assistance for sit to stand and chair/bed to chair transfer. Under section H - bladder and bowel the resident was coded for having an ostomy (an opening in the abdominal wall to redirect waste out of the body). Under section I - Active Diagnoses the resident was diagnosed with muscle wasting and atrophy (conditions where the muscle tissue shrinks and weakens), muscle weakness (reduced capacity to exert force with your muscles), age-related osteoporosis without current pathological fracture (progressive bone density loss in older adults). Record review of Resident #3's comprehensive care plan dated 05/08/2026 revealed no focus or interventions for assisting the resident with ADLs, transfer, and repositioning. Record review of Resident #3's physical and history dated 02/27/2026 revealed the resident was diagnosed with end-stage renal disease (the final stage of a chronic kidney disease, when kidney function drops to less than 15% of normal capacity), age related physical debility (progressive functional decline, muscle weakness, slow gait, and severe fatigue), and pleural effusion (an abnormal buildup of excess fluid in pleural space between the lungs and chest wall). Record review of a facility incident, undated, for Resident #3's fall did not include detailed information such as interviews with key personnel, Resident #3, corrective actions taken against CNA C, what documentation was reviewed, and what steps were taken to assess the scope of effected residents. Record review of LVN H's fall risk assessment for Resident #3 dated 06/28/2026 at 9:36 p.m. revealed Resident #3 was scored at a 9 with the significance being moderate fall risk. Record review of LVN H's progress note for Resident #3 dated 06/28/2026 at 9:38 p.m. read in part, CNA called this nurse into resident room. Resident was lying on the floor noted 2 hematomas (localized collection of clotted or pooled blood) left forehead/eye. Complaints of pain 9 out of 10 (with 10 being the worst) to her head and hearing loss to right ear, assessed vital stats (blood pressure) 184/85 (pulse) 85 (oxygen saturation) 93 at 2 liters per minute, range of motion intact to upper and lower extremities. Physician on call, DON, supervisor and family member notified. 911 was called at 9:05 p.m. ambulance arrived at 9:23 p.m. and resident was taken via stretcher to hospital 9:35 p.m. Appears and/or stated to be in pain. Describes the pain as: intermittent, locations of pain: head, pain relieving interventions used at this time: p.m. medication. Record review of RN K's (continued on next page)		

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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.			
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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	progress note for Resident #3 dated 06/29/2026 at 2:02 a.m. read in part, resident returned from hospital, diagnosis status post fall, pleural effusion. Resident continue on 2 liters per minute nasal cannula oxygen. Cough was noted during admission. As per report head computed tomography scan was completed with negative results. No new orders sent with paperwork. Physician on call was notified of readmission Record review of Resident #3's hospital discharge date d 06/29/2026 read in part, arrival time 06/28/2026 at 9:45 p.m. Patient diagnosis: fall; pleural effusion; scalp contusion (soft tissue injury caused by blunt impact). Discharge location: follow up with primary care provider within 3-5 days.computed tomography to spine cervical without contrast completed. Order details: discharge to home resume normal activity. Record review of Resident #3's Therapy Screen completed by DOT on 06/30/2026 read in part, the resident exhibited a change in one area under falls. The recommendations implemented were, no skilled therapy intervention indicated, will continue to monitor patient. Record review LVN L's weekly skin assessment of Resident #3 dated 07/03/2026 at 6:26 a.m. read in part, skin color: normal, temperature skin: warm, bruise present: Yes, Location, measurements of bruising: left aspect facial/periorbital region (around the eye to include eyelids, eyebrows, and the bony socket), 7.5CM x 8.5. left upper shoulder 7CM x 5CM status post recent fall skin tear present: no, abrasion present: no, laceration present: no. rash present: no, moisture associated skin damage present: no. other skin findings present: no. Record review of the Provider Investigation Report for incident intakes did not include detailed information such as interviews conducted with key personnel, what documentation was reviewed, and what interventions the facility took to correct or prevent further incidents. This included the following separate intakes involving Resident #1 and #2. In an interview on 07/07/2026 at 9:55 a.m., the Administrator stated Resident #1 was speaking to Hospice Social Worker and her about a time he had left the facility and went to the bank to withdraw \$2,000 while he was in the middle of a pending Medicaid application due to lack of reported income. She stated Resident #1 had told her the money was for his family member. She stated the facility was unsuccessful in contacting family members to provide documents for Resident #1's finances so the Hospice Social Worker assisted. She stated she created an APS report and self-report to the state on concerns for exploitation and neglect based on Resident #1 reporting he gave \$2,000 to a family member. She stated she did not see the family member visit Resident #1 for one week after creating the report. She stated Resident #1 had a previous exploitation case confirmed by APS upon his admission into the facility. She stated that the facility contacted the Ombudsman to speak to Resident #1and family due to possibility of discharge for nonpayment. She stated during the investigation the facility tried to minimize Resident #1 from leaving the facility with the alleged family member but was unsuccessful. She stated that she notified the alleged family member the facility would not be doing anything further on the family's behalf until she obtained a POA. She stated she referred the alleged family member to attorney services offered by the facility's corporate partners. She stated the resident had his Medicaid application approved following the involvement of APS who assisted family member in obtaining POA for Resident #1. She stated she did not complete any interviews with staff or residents for the investigation. She stated she let APS take over the investigation and contacted a foster home advisory service (a third-party business who assisted residents and families with finding a foster home in their area) for her portions of the investigation. She stated she did not complete a 3613-A form (provider investigation report for self-reported incidents) and only uploaded the digital Provider Investigation Report to TULIP. She stated she only completed one interview with Resident #1 and utilized the Hospice Social Worker as a translator. She stated She stated the 3613-A form was used to provide status on investigations, assist in resolving allegations, document the interventions put in place, and what the investigation findings were. She (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	identified herself as the individual responsible for completing the 3613-A form and thoroughly investigating all allegations and incidents. She stated that the 3613-A form would have had to been completed within 5 days of the investigation along with the initial findings. She stated that the 3613-A form needed to be emailed, faxed, uploaded to TULIP, and stored in the facility's physical investigation copy. In a follow-up interview on 07/07/2026 at 5:33 p.m. regarding Resident #2, the Administrator stated she was notified on 06/22/2026 about Resident #2's fall on 06/21/2026. She stated that she was notified on 06/27/2026 about Resident #2's hospital transfer following significant findings from an x-ray on 06/26/2026. She stated because Resident #2's fracture was not determined on the initial fall date the facility self-reported under the allegation of neglect. She stated the interventions included speaking with Resident #2's family member about interventions in the form of a bolster (concave) mattress, continue with incontinent briefs, address Resident #2's fixation on restroom breaks, change to hourly monitoring, start antibiotic regimen for urinary tract infection, and placed the resident's bed against the wall. She stated for her investigation she interviewed only LVN M who was the nurse who assessed Resident #2 on 06/26/2026 and ordered x-rays. She stated she did not document her interview, collect a statement, conduct safety surveys, or interview Resident #2. She stated Resident #2 could engage in simple conversations and sharing needs and pain but had difficulty with recalling events and elaboration. She stated that she would be responsible for compiling the information collected during the investigation and delegating the tasks to nursing supervisors to complete on her behalf. She stated it needed to be done because it ensured the residents' safety as priority and to prevent future incidents. She stated that her investigation was not thorough as to the adherence of the facility's abuse and neglect policy. She stated that the investigation would determine if there were interventions to prevent or mitigate the injuries. She stated that the investigation would be provided to Texas HHSC for further review. She stated that this was a requirement per CMS and with her license to thoroughly investigate self-reported incidents. In a follow-up interview on 07/07/2026 at 5:45 p.m. regarding Resident #3, the Administrator stated she could not interview Resident #3 or CNA C because she did not have enough knowledge in Spanish. She stated that it was reported to her via translation from her ADON A that, CNA C was providing incontinent care to Resident #3 and had gone to the other side of the bed, but Resident #3 was trying to get off the bed. She stated it was reported to her that Resident #3 had placed herself on her side while CNA C walked to the other side of the bed. She stated that based on CNA C's written statement abuse, neglect, and quality of care concerns were ruled out because it was the assumption Resident #3 was attempting to self-transfer. She stated she did not interview Resident #3 that ADON A was tasked with this. She stated that she was notified by ADON A that Resident #3 was trying to maneuver herself to get out of bed. She stated that Resident #3 suffered minor injuries to her eyebrow and scalp but could not recall orientation. She stated Resident #3 was sent to the hospital immediately following the fall and it was determined there were no major injuries. She stated Resident #3 was discharged from the emergency room within 2-3 hours from leaving the facility. She stated CNA C was not suspended and did not receive further training on transfers and repositioning. She stated she was unable to understand CNA C's written statement because it was in Spanish and relied on translation for understanding. In an interview on 07/07/2026 at 4:09 p.m., ADON A stated she did not participate in the investigation involving Resident #1. She stated she was not notified about Resident #2's fall until 06/22/2026 when she was reading progress notes entered. She stated monitored for pain, change in condition, and followed Physicians orders. She stated when she saw Resident #2 she would assess for pain. She stated Resident #2 did not display any variation from her baseline. She stated she did not participate in the investigation involving Resident #2. She stated the (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	DON was notified on 06/28/2026 about Resident #3's fall but not her directly. She stated she was not present during Resident #3's fall and she did not participate in any portion of the investigation. She stated the DON had collected the statements for the fall with Resident #3. She stated she does not think CNA C was suspended. She stated she does not know if there was a facility investigation conducted. She stated that Resident #3 said she was feeling better post fall and hospital visit on 06/29/2026. She stated Resident #3's injuries were bruises to the left eye/eyebrow area. She stated the resident did not suffer a fracture or internal bleeding. In an interview on 07/07/2026 at approximately 12:05 a.m., the DON notified the surveyor she would not be attending work during the day on 07/07/2026. An interview with the DON was not obtained prior to surveyor exit on 07/07/2026 at 6:30 p.m. Record review of the facility's policy titled, Abuse/Neglect dated 03/29/2018 read in part: .Residents should 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 will provide and ensure the promotion and protection of resident rights. It is each individual's responsibility to recognize, reports, and promptly investigate actual or alleged abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property abuse and situation that may constitute abuse or neglect to any resident in the facility. (Procedures, F - Investigation) Comprehensive investigations will be the responsibility of the administrator and/or Abuse Preventionist. All allegations of abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident property and injuries of unknown source will be investigated. (1) The administrator in consultation with Risk Management Department will be responsible for investigating and reporting cases to the HHSC. (6) the Abuse preventionist and/or administrator will conduct a thorough investigation of incident(s). A copy of the written report will accompany any personnel action deemed necessary.(G - Protection) The facility will take necessary measures to protect resident and employees from harm during and following an abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property investigation. Record review of the Texas Health and Human Services Commission document, Long-Term Care Regulation Provider Letter, undated, read in part under 2.0 Policy Details & Provider Responsibilities: A provider must: ensure a thorough investigation is conducted and documented in the PIR .		