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	04/14/2026

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

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure that a resident who needed respiratory care was provided such care, consistent with professional standards of practice for 4 (Resident #2, Resident #46, Resident #62 and Resident #79) of 12 residents observed for oxygen management. The facility failed to properly bag and store an oxygen nebulizer for Resident #2, and Resident #46 The facility failed to clean the oxygen concentrator air filter for Resident #62 and Resident #79 while the oxygen was in use.Findings included: Resident #2: Record review of Resident #2's face sheet dated 04/02/2026 revealed a [AGE] year-old male with an admission date of 03/30/2026. Record review of Resident #2's history and physical dated 04/02/2026 revealed that the resident had diagnoses including acute and chronic respiratory failure with hypoxia (a condition where the lungs cannot provide enough oxygen to the body), dyspnea (shortness of breath), and dependence on supplemental oxygen (requiring oxygen support to maintain adequate breathing). The record revealed that the resident required oxygen therapy to support respiratory function. Record review of Resident #2's admission assessment MDS dated [DATE] revealed under Section GG (Functional Abilities and Goals) that the resident required assistance with ADLs. The MDS revealed under section I – Active Diagnoses; the resident had debility, cardiorespiratory conditions, and respiratory failure. The MDS revealed under section O – Special Treatments, Procedures and Programs; the resident required oxygen therapy. The MDS revealed under section J – Health Conditions, Resident #2 had shortness of breath with trouble breathing with exertion (walking, bathing, transferring). Record review of Resident #2's care plan dated 03/30/2026 revealed the resident had oxygen therapy related to ineffective gas exchange (inability of the lungs to properly exchange oxygen and carbon dioxide). The care plan included interventions for staff to monitor signs and symptoms of respiratory distress, including changes in respirations, oxygen levels, confusion, and increased heart rate. The care plan revealed staff were to provide interventions to provide assistance with oxygen equipment, including ensuring proper positioning, use of oxygen delivery devices, and monitoring effectiveness of treatments. During an observation and interview on 04/12/2026 at 1:34 p.m. with Resident #2, he stated that he needed his nebulizer to breathe better, and he used it especially when he turned sides on his bed and he needed help breathing. Resident #2 stated he had taken off his nebulizer in the morning and had left it on his nightstand to use it later. Resident #2 stated that staff had been going to check on him through the day, but that no one had cleaned or stored his nebulizer. Resident #2's nebulizer was observed next to him on his night stand; it was not bagged and out in the open. (continued on next page)

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/13/2026 at 2:16 p.m., CNA A stated that nebulizer equipment should have been properly sanitized after each use, then placed in a bag and stored appropriately to prevent exposure to environmental contaminants. CNA A stated that failure to properly store the nebulizer created a risk of contamination from dust, lint, or other airborne particles, which could enter the equipment and be inhaled by the resident. CNA A stated that such contamination had the potential to negatively impact the resident's respiratory system or lungs, increasing the risk of illness or infection. CNA A stated that all staff providing care to residents were responsible for ensuring nebulizers were cleaned, sanitized, and stored according to facility expectations. During an interview on 04/13/2026 at 2:43 PM, LVN B stated that all staff working directly with residents were responsible for ensuring nebulizer equipment was properly sanitized and stored when not in use. LVN B stated it was not appropriate to leave Resident #2's nebulizer exposed on the nightstand, as this increased the likelihood of contamination. LVN B stated that improper sanitation and storage of nebulizer equipment created a significant risk of infection, which could worsen the resident's respiratory condition if contaminated equipment was used. LVN B stated there was a safety concern related to improperly stored tubing, noting it could become tangled or create a tripping hazard, potentially resulting in a fall and injury to the resident or any visitors who went into Resident #2's room. During an interview on 04/14/2026 at 1:33 p.m., with the DON, she stated nasal cannulas and nebulizer masks were to be stored in the plastic bag when not in use to prevent any cross contamination. She stated that all staff was responsible for ensuring that oxygen materials were stored properly. She stated the risk to the resident could be residents getting sick from using a contaminated nebulizer mask or nasal canula. During an interview on 04/14/2026 at 1:53 p.m. with the Administrator, she stated that staff working in the facility and provided direct care to the residents, were responsible for sanitizing, bagging, and properly storing nebulizer equipment when not in use. The Administrator stated that failure to follow proper infection control practices could result in the nebulizer becoming contaminated, placing Resident #2 at risk for infection if the equipment was used without being properly cleaned. The Administrator stated there was a risk of cross-contamination, which could lead to illness affecting the resident's mouth, lungs, or nasal passages, particularly given the direct route of administration through respiratory equipment. Record review of the Nursing Policy and Procedure Manual, titled Oxygen Administration, not dated, revealed in part: Oxygen therapy includes the administration of oxygen (O2) in liters/minute (L/min) by cannula or face mask to treat hypoxemic conditions caused by pulmonary or cardiac diseases. O2 therapy is also prescribed to ensure oxygenation of all body organs and systems. The amount of oxygen by percent of concentration or L/min, and the method of administration, is ordered by the physician. The administration, monitoring of responses, and safety precautions associated with it are performed by the nurse. The nasal cannula delivers 22-40 % oxygen and is the most common, inexpensive, and easiest device to use. Common oxygen sources for long-term administration include cylinder (portable or stationary) or wall system near the resident's bed or concentrator. Goals 1. The resident will maintain oxygenation with safe and effective delivery of prescribed oxygen. 2. The resident will maintain an effective breathing pattern with administration of oxygen. 3. The resident will be free from infection. Procedure 11. Change the tubing (including any nasal prongs or mask) that is in use on one patient when it malfunctions or becomes visibly contaminated. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident # 46 Record review of Resident # 46's admission record dated 04/14/2026 revealed a [AGE] year-old female with an original admission date of 12/28/2023 and a readmission date of 04/27/2024. Record review of Resident # 46's history and physical dated 12/01/2025 revealed a diagnosis of mild persistent asthma with acute exacerbation (worsening of chronic, asthma symptoms that requires increased medication). Record review of Resident # 46's quarterly MDS dated [DATE] revealed a BIMS score of 15 indicating intact cognitive function. Record review of Resident #46's clinical physician orders revealed an active order dated 08/15/2025 for Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML (Ipratropium-Albuterol), 1 application inhale orally one time a day for shortness of breath. Record review of Resident # 46's care plan revised 02/25/2026 revealed Resident # 46 had altered respiratory status/ difficulty breathing/ shortness of breath interventions did not mention anything about applying nebulizer treatment. An observation on 04/12/2026 at 10:20 a.m., revealed a nebulizer mask not in use, laying on top of the nebulizer machine uncovered, the Resident was not in the room. Resident #62 Record review of Resident #62's admission record dated 04/14/2026 revealed a [AGE] year-old female with an original admission date of 03/28/2024 and a readmission of 05/29/2025. Record review of Resident # 62's acute episodic visit note dated 02/27/2026 revealed a diagnosis of heart failure. Record review of Resident #62's comprehensive MDS asessment dated 03/27/2026 revealed a BIMS score of 03 indicating severe cognitive impairment. Section O- special treatments, procedures and programs revealed the use if oxygen therapy. Record review of Resident # 62's clinical physician orders revealed an active order dated 03/13/2026 for oxygen at 2 liters per minute via nasal canula for shortness of breath. Record review of Resident # 62's care plan revised on 03/24/2026 revealed Resident # 62 had oxygen therapy related to heart failure. Interventions included administering oxygen at 2 liters per minute via the nasal canula. An observation on 04/12/2026 at 10:43am in Resident # 62's room revealed an oxygen concentrator machine with a dirty oxygen filter while in use. Resident # 62 was asleep in bed. Resident #79 Record review of Resident #79's admission record dated 04/14/2026 revealed a [AGE] year-old female with an admission date of 08/28/2024 and a readmission date of 09/13/2024. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of resident # 79's history and physical dated 11/17/2025 revealed a diagnosis of chronic respiratory failure with hypoxia (long term condition where the lungs can not adequately transfer oxygen into the blood stream). Record review of Resident # 79's quarterly MDS assessment dated [DATE] revealed a BIMs of 08 indicating moderate cognitive impairment. Section O- special treatments, procedures and programs revealed the use of oxygen therapy. Record review of Resident # 79's clinical physician orders revealed an active order dated 08/18/2025 for oxygen at 2 liters per minute via nasal canula for shortness of breath. Record review of Resident # 79's care plan revealed Resident # 62 had oxygen therapy related to altered cardiovascular status. Interventions included administering oxygen as ordered. An observation on 04/12/2026 at 10:54am in Resident # 79's room revealed an oxygen concentrator machine with a dirty oxygen filter while in use. Resident # 79 was asleep in bed

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide safe and secure storage of medications for 3 of 4 medication carts (Halls E, B and C). 1. -The facility failed to ensure Blood Glucose Strips bottle was dated when opened according to manufacturer's specifications in two of two nurses' medication carts. 2. -The facility failed to ensure opened bottles of Liquid Protein Supplement was dated when opened according to manufacturer's specifications in two of two Med Aide's medication carts. 3. -The facility failed to ensure medication cart drawers were clean. 4. -The facility failed to ensure medication bottles stored in medication carts were free of dried dripping; staff were not storing personal care items removed from residents' rooms, discontinued medications and money in the medication carts.5. -The facility failed on 04/12/2026 by leaving a dixie cup at bedside of Resident #66 with leftover medications and a tongue depressor in it, exposed and within reach of other residents.These failures could affect residents that received diabetes medications and nutritional supplement from the facility. Findings included:During an observation and interview on 4/13/26 at 10:56 a.m. with LVN F assigned to the 200 Hall revealed: -There were two bottles of Blood Glucose Strips that were not dated when opened. The label on the bottle documented to use within 6 months after first opening or before expiration date 08/13/2027. LVN F said they had been trained to date the bottles and boxes when opened. -There was a bottle of Milk of Magnesia stored in the drawer with dried drippings on the side of the bottle. LVN F said they had been trained to clean the liquid medication bottles after each use. -There were dried drippings on the bottom of the drawer where medication bottles were stored. LVN F said all of the nurses were responsible for keeping the medication carts clean. Medication Cart 300 Hall: During a observation and interview on 4/13/26 at 11:09 a.m. with LVN D revealed: -There were air pods, dollar bills, multiple coins, upper denture stored in a plastic glove and a coin purse stored in one of the drawers in the medication cart. -There were 5 bottles of eye drops stored together in a small plastic container. LVN D, said, When we remove the bottles from the boxes, we just store them all together in the plastic container. How should they be stored? -There was a bottle of Iron Supplement Liquid, a bottle of Geri-Tussin, and a bottle of Milk of Magnesia stored in a drawer that had dried drippings on the sides of the bottles. -There was an open large plastic bag stored in the bottom drawer of the medication cart that contained a can of air freshener, a box that contained a perfume bottle, chap stick, deodorant bottle and other personal care products. There was another bag that contained over the counter medications. LVN said, All of those things stored in those two plastic bags are items that we removed from the residents' rooms that they are not allowed to have, and this is where we stored them. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-There was an opened bottle of Nystatin Topical Powder stored in one of the drawers in the medication cart without a cap that had white residual on the top of the sides of the bottle. -There were two large, opened bags of Lollipops stored in one of the bottom drawers in the medication cart. LVN D, We give Lollipops to some of the residents, so that is why they are stored in the medication cart. Medication Cart used by the Med Aides for the 200/300 Hall revealed: During an observation and interview on 04/13/26 11:23 a.m. with Med Aide G revealed: -There were two small plastic containers with pudding that were not dated. Med Aide G said he used them to mix crushed medications to administer to some of the residents. He said, I got those pudding containers this morning from the refrigerator where snacks are stored for the residents. He said that he did not know that the containers needed to be dated. -There was an opened bottle of Active Liquid Protein that was not dated when opened. The label on the bottle documented, Do Not Refrigerate. Shelf stable. 3-month shelf life from date opened. Date Opened: left blank. Med Aide G stated, I did not know that. -11:27 a.m. There was a bottle of Valproic Acid Solution and a bottle of Lactulose stored in a drawer. The bottles had dried, dripping on the sides of the bottles. -11:27 There was a bottle that contained Metformin 500 mg, and two bottles that contained Galantamine ER stored in a drawer. The drawer was dusty and had particles on the bottom of the drawer. Med Aide G said, Those are discontinued medications that are stored in the medication cart. -11:29 a.m. There was a medication box that contained Fluticasone Propionate Nasal Spray that had part of the pharmacy label torn off. During an interview on 4/13/26 12:00 p.m. with the facility's Compliance Nurse said the nurses had been trained to date nutritional supplement bottles according to manufacturer's specification; trained to date Blood Glucose Strip bottles when opened according to manufacturer's specification. She said the nurses and Med Aides had been trained to immediately remove discontinued medications from the medication carts and not to store resident personal items in the medication carts. The state surveyor requested facility's policy and procedure on storage of medications and was not provided befor exit. Findings included: Record review of Resident #66's face sheet dated 04/14/2026 revealed a [AGE] year-old female with an original admission date of 08/17/2018. Record review of Resident #66's history and physical dated 07/26/2024 revealed that the resident had diagnoses including unspecified dementia (decline in memory and thinking abilities), muscle weakness (reduced strength), abnormal gait (difficulty walking safely), and cognitive communication deficit (difficulty understanding or expressing thoughts). Record review of Resident #66's annual MDS assessment dated [DATE] revealed she had a BIMS of 0 indicating she was severely cognitively impaired. The MDS revealed under Section GG (Functional (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Abilities and Goals) that the resident required assistance with ADLs. The MDS revealed that the resident demonstrated cognitive impairment and required supervision and assistance with daily care tasks. Record review of Resident #66's care plan dated 04/01/2026 revealed the resident had diagnoses including dementia and cognitive communication deficit, requiring ongoing monitoring and assistance. The care plan included interventions for staff to administer medications as ordered and monitor effectiveness and side effects. During an observation and interview on 04/12/2026 at 10:02 a.m. with Resident #66, she was asked if she knew which medication she was supervised with that was left inside the dixie cup. Resident #66 was confused and could not provide an answer to the surveyor. Resident #66 mumbled under her breath, and the attempt to interview concluded. During an interview on 04/13/2026 at 2:24 PM with CNA A, she stated that it was likely the contents remaining in the dixie cup were medication for Resident #66. CNA A stated that the staff member responsible for supervising the medication administration process was also responsible for properly disposing of any remaining medication by placing the cup in the designated biohazard waste bin located on the medication carts. CNA A stated that leaving the cup unattended in the resident's room posed a risk to infection control practices. She stated that if another resident accessed the medication and ingested it, it could result in gastrointestinal illness or other adverse health effects. During an interview on 04/13/2026 at 2:39 PM, LVN B stated that the cup most likely contained residual medication and stated that it was not appropriate to leave it unattended in the resident's room after administration. LVN B stated that the nurse or staff member who administered the medication was responsible for ensuring proper disposal of any remaining medication by discarding it in the designated trash bin within the medication cart. LVN B stated that leaving medication unattended created a safety risk, particularly for residents with cognitive impairments such as dementia, who could wander into the room and ingest the medication. LVN B stated this could result in illness or potentially trigger an allergic reaction depending on the resident's sensitivities. During an interview on 04/14/2026 at 2:45 p.m. with the Corporate Nurse, she stated that it was not acceptable practice to leave leftover medications in a resident's room following administration. The Corporate Nurse stated that medications left unattended created a significant safety risk, as another resident could enter the room and inadvertently ingest the medication, potentially resulting in illness or triggering an adverse or allergic reaction depending on the resident's medical history and sensitivities. The Corporate Nurse stated that improper disposal of leftover medications also presented an infection control concern. She stated that exposed medications could become contaminated through environmental exposure, increasing the risk of cross-contamination if handled or ingested. The Corporate Nurse stated that failure to properly dispose of medications in accordance with facility expectations could compromise resident safety, leading to preventable health complications, including gastrointestinal distress, medication-related adverse events, or the spread of contaminants within the resident care environment. Record review of the facility policy, not dated, titled Medication Administration, revealed the facility did not have a policy specifically outlining procedures for the disposal of leftover medications or clear guidance on how staff were to properly discard residual medications following administration. The Corporate Nurse stated at 3:14 PM that the facility did not have a specific policy addressing procedures of disposal for leftover medications.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record reviews, the facility failed to store food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for kitchen sanitation and food storage.-The facility failed to keep food containers stored in the dry storage room free of food particles.- The facility failed to ensure food stored in the dry storage room was properly stored, labeled, and dated.-The facility failed to keep liquid bottles stored in the dry storage room and refrigerator free of dried drippings and grease build-up.-The facility failed to keep the ice machine free of white calcium build-up.These failures could place residents who received meals and/or snacks from the kitchen at risk of foodborne illnesses. Findings included:Dry Storage Room:During an observation and interview on 4/12/26 at 9:31 a.m. with [NAME] E revealed: -9:32 a.m. Four small clear plastic containers that contained breakfast cereal were covered with plastic wrap and were not dated. It was observed that there were food particles and several pieces of breakfast cereal on the bottom of the plastic containers where the breakfast cereal bowls were stored.-9:33 a.m. There was a disposable food plate that contained two sunny side eggs, beans, bacon and bread covered with a paper napkin stored on the metal shelf on top of metal food cans; Seashell pasta was stored in a plastic bag tied in a knot, that was not dated. -9:34 a.m. Multiple food plastic containers stored on metal shelves had grease build-up and had food particles; one of the squared plastic food containers where the pasta bags were stored had food particles and pieces of spaghetti on the bottom of the container.-9:35 a.m. food cans stored on the metal shelves had food particles on top of the cans. A large plastic container that contained macaroni noodles had a cracked plastic lid. The plastic lid was greasy and had food particles.-9:37 a.m. food plastic and glass bottles stored on a meal tray on one of the shelves had multiple bottles with dried drippings on the tops and sides of bottles, were greasy and some of them had food particles on the sides of the bottles. The bottom of the meal tray where the bottles were stored had dried food stains, had grease build up and had food particles.-9:40 a.m. opened bag of corn chips dated as opened on 4/02/26 was not sealed was stored on the metal shelve.-9:41 a.m. opened bag of cinnamon sticks was opened, was not sealed or dated when opened was stored in a plastic food container. The lid was greasy and had food particles.-9:42 a.m. opened bags of Cinnamon Sugar, Roasted Chicken Gravy, were stored in food plastic containers. It was observed that the bags were opened, were not sealed, and/or dated when opened. The lids to the plastic containers were greasy and had food particles. Multiple small bags of crushed corn stored in plastic containers covered with food particles. -9:47 a.m. an opened bag of Flavored Gray that was partially closed with a metal binder clip. The bag was not dated when it opened.9:51 a.m. A large container of Chocolate Fudge Frosting opened 01/09/26 had a cracked lid.-9:54 a.m. Large plastic oil container had oil dripping on the side of the bottle.Refrigerator:-10:10 a.m. There was a plastic bottle of chocolate syrup dated as opened 3/12/26 dried drippings on the side of the bottle.-10:11 a.m. A plastic bottle that contains tomato pasted dried drippings on the side of the bottle.-plastic syrup dispenser dated 3/05/26 that contained chocolate syrup had dried dripping on the lid and below the handle on the bottle.-A large plastic container of cottage cheese dated 2/02/26 stored on the shelf had a cracked lid.Ice Machine:During an observation and interview with Dietary Supervisor on 4/12/26 at 10:13 a.m. revealed the ice machine had white calcium build-up on the front directly below the ice maker and around the edges of the Bin Door and white calcium build-up and white particles. The Dietary Supervisor said that they had attempted to remove the white calcium build-up and were not able to remove it.Review of the Cleaning Schedules dated April 2026 provided by the Dietary Supervisor revealed did not list the ice machine.In an interview at 04/13/26 at 12:15 p.m. with the director of Food and Nutrition said the thermometers were checked daily and was not aware that some of the Digital Type Pocket Thermometer was not working and said that he had not used the digital thermometer for a while.During an interview on 04/14/26 at 2:10 p.m. with facility's Consultant (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dietitian revealed that she conducted weekly visits and did not leave any notes regarding her findings and/or recommendations. She said she had not noted any concerns related to food storage and cleanliness. She said that she did not conduct deep observations of the kitchen.Review of facility's Food Storage and Supplies policy dated 2012 provided by director of Food and Nutrition revealed:All facility storage areas will be maintained in an orderly manner that preserves the condition of food and supplies. We will ensure. The storage area is very clean, organized, dry and protected from vermin, and Insects. Procedures: Dry monk foods such as flour, sugar are stored in seamless metal or plastic containers with tight covers or bins which are easily sanitized. Containers are labeled. Containers are clean regularly. Open packages of food are stored in closed containers with covers or sealed bags and dated as to when opened.

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F 0575 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. Based on observation and interview the facility failed to post in a form and manner accessible and understandable to residents and resident representatives a list of names, addresses (mailing and email, and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit for 1 of 1 buildings reviewed for postings. The facility failed to ensure the number to HHS Long Term Care Regulatory (state survey and certification agency) number for filing grievances, or complaints or suspected violations of state or Federal violations was posted in an area where it was accessible to all residents and family members. This failure could place residents at risk of lack of knowledge of who to contact should they require advocacy, investigation, and not knowing their rights, how to exercise their rights, or investigations into violations of their rights. Findings include: In observation on 04/12/2026 at 2:00 pm revealed postings to include HHSC compliant number and statement that resident may file a compliant with State Survey Agency were on the wall on the 300 hall. There were no postings on the 100, 200 and 400 hall. In a confidential group interview on 04/14/2026 at 10:00 am with 9 residents revealed 7 of them did not know how to file and contact the State Survey Agency if they had complaints. They stated that the only number that they were aware of was the administrators number as it was posted in all hallways, but that they would like to be aware of how to file a complaint directly with the State Survey Agency. One resident stated that she had noticed the State Survey Agency number was posted in the 300 hallway, but that she rarely went to that hallway unless she was going to the activities room. An interview on 04/14/2026 at 2:46 pm with the administrator revealed that the number to the State Survey Agency was posted on the wall of the 300 hallway. She stated that it was the only location where that information was posted, but that her contact information as the abuse coordinator was posted throughout the building and if family member or residents wanted that information, the residents could ask any staff member and they would provide that information to the family or resident. She stated that there was a possibility that residents would not know how to report their concerns directly to the State Survey Agency and that it was something that all residents and family members should have easy access to so that if incase there were any concerns, they knew how to file a report. She stated that there was not a policy regarding required postings.

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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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review , the facility did not ensure prompt efforts were made to document a resident grievance for 1 (Resident #65) of 9 residents reviewed for grievance resolutions. The facility failed to promptly document grievances regarding a complaint regarding customer service voiced by Resident #65 and Responsible Party. This failure placed resident at risk of not having their grievances resolved. Findings included: Resident # 65 Record review of Resident # 65's admission record dated 04/14/2026 revealed an [AGE] year-old female with an original admission date 0f 08/15/2025. Record review of Resident # 65's diagnosis list dated 04/14/2026 revealed a diagnosis of dementia (progressive decline in mental ability specifically in memory, thinking and behavior) Record review of Resident # 65's quarterly MDS assessment dated [DATE] revealed a BIMs score of 10 indicating mild cognitive impairment. Record review of resident # 65's care plan revealed Resident # 65 had impaired cognitive function/ dementia or impaired through process. Interventions included discussing concerns about confusion, disease process, nursing home placement with resident /family/caregivers. In an interview on 04/13/2026 at 2:43 pm with Resident # 65's responsible party, revealed that on 03/30/2026, Resident # 65 called him to tell him that she had been asking one of the medication aides for help to be laid down back in bed. She had stated to him that she had asked her multiple times and that she had told her that she was too busy and walked away. He stated that he came to the facility and he verbally notified the DON of this incident the day it had happened on 3/30/2026. He stated that he was not told to file a grievance, he was told that the DON would take care of it and the facility never followed back up with him regarding this concern. In an interview on 04/14/2026 at 1:33 pm with the DON, she stated that on 03/30/2026 Resident # 65's responsible party came to the facility to tell her that Resident #65 had called him to tell him that she felt that medication aide had been rude to her. She stated that she might have had a conversation with him about removing the medication aide from Resident #65's care but she could not recall. She stated that this was not documented. She stated that she thought it was resolved. She stated that the purpose of the grievance form awas to ensure that any complaints were followed up on. She stated that she would have had to complete a grievance form to ensure that it was addressed and that there was supporting documentation to ensure residents needs were met. She stated that the risk of not completing a grievance form was that there would be lack of communication between the facility and the family or resident and the concern would not be resolved. In an interview on 04/14/2026 at 2:46pm with the administrator revealed that she was made aware of this situation by corporate as Resident # 65's responsible party reported it to the company complaint hotline. She stated that she received an email from the corporate office on 04/07/2026 regarding the medication aide refusing to provide care to the resident. She stated she was the grievance officer. She stated that the facility followed up on this, but there was no supporting documentation. She stated that the DON should have filed a grievance as soon as she was informed of the concern. She stated that the risk of not filing a grievance would be lack of communication and the whole team would not be aware of the situation. She stated that the resident would feel like the concerns weren't taken seriously. Review of facility policy titled Grievances revised 11/2/1016 read in part . The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have. The grievance official will oversee grievance process, receive and track grievances to their conclusion, issue written grievance decisions to the resident.

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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** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs for 1 resident (Resident #46) of 9 residents reviewed for care plans. The facility failed to ensure comprehensive person-centered care plan for Resident #46 addressed the use of the nebulizer under interventions. This failure could affect residents and put them at risk for not receiving care and services to meet their needs. Findings Included: Record review of Resident #46's admission record revealed a [AGE] year-old female with an original admission date of 12/28/2023 and a readmission date of 04/27/2024. Record review of Resident #46's history and physical dated 12/01/2025 revealed a diagnosis of mild persistent asthma with acute exacerbation (chronic respiratory condition with regular symptoms that occasionally worsen suddenly, requiring prompt management). Record review of Resident #46's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 15 indicating intact cognitive function. Record review of Resident # 46's clinical physician orders revealed an active order dated 08/15/2025 for ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml to be inhaled orally 1 application as needed. Record review of Resident # 46's care plan revised 02/25/2026 revealed Resident # 46 had altered respiratory status/difficulty breathing/shortness of breath. Interventions did not address the use of the nebulizer treatment, rather it stated to provide oxygen as ordered. In an interview on 04/14/2026 at 1:08 pm with the MDS nurse, revealed care plans were to detail the care of the resident and that it was patient centered. She stated that the care plan should mention the nebulizer treatment as it was one of the interventions being provided to the resident. She stated that one risk might have been that the resident would not received the treatment as ordered. She stated that it was the responsibility of the MDS nurse and nursing to ensure care plans were updated correctly. In an interview on 04/14/2026 at 1:33 pm with the DON revealed the purpose of the care plan was to ensure residents needs were being met and that the care required was being followed. She stated that the care plan should have been updated to reflect the intervention of the nebulizer treatment as it was a treatment that was being administered. She stated that it was the responsibility of nursing, nursing administration(DON and ADONs) and MDS nurses to ensure it was updated correctly. She stated that there was no risk to the resident if nebulizer treatment was not included in the care plan as there was an order for it. In an interview on 04/14/2026 at 2:46 pm with the Administrator revealed the purpose of the care plan was to know how to care for the resident. She stated that care plans were updated as needed and quarterly. She stated that the use of a nebulizer treatment needed to be addressed in the care plan to ensure all staff knew about the use of the nebulizer for resident's care. She stated that a risk to the resident would be the treatment not being administered. She stated that the MDS nurse, and floor nurses were responsible to ensure that it was updated correctly. Review of facility policy titled Comprehensive Care Planning not dated read in part The comprehensive care plan will describe the following- The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being .

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide proper treatment and care to maintain mobility and good foot health in accordance with professional standards of practice, including to prevent complications from the resident's medical conditions and if necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments for 3 (Residents #29, #57 and #93) of 18 residents reviewed for foot care.The facility failed to ensure Resident #29, Resident #57, and Resident #93 who required assistance with ADLs, did not have long and dirty fingernails.The facility failed to ensure Resident # 93 who required assistance with ADL's did not have long toenails.This deficient practice placed residents at risk of poor foot hygiene and decline in residents' physical condition.Findings include: Resident #29. Record review of Resident #29's face sheet dated 04/13/2026 revealed an [AGE] year-old male with an admission date of 11/27/2023.Record review of Resident #29's history and physical dated 01/13/2026 revealed that the resident was an [AGE] year-old male with a history of cerebrovascular accident (stroke affecting brain function), left-sided hemiplegia (paralysis on one side of the body), contractures (permanent tightening of muscles limiting movement), and muscle wasting (loss of muscle mass). The record revealed the resident was wheelchair bound with reduced strength on the left side and contractures to the upper extremity, requiring assistance with mobility and ADLs. Physical examination revealed limited range of motion, weakness, and continued need for assistance due to functional decline. Record review of Resident #29's annual MDS dated [DATE] revealed a BIMS score of 15, indicating the resident was cognitively intact. The MDS under Section GG (Functional Abilities and Goals) revealed that the resident required assistance with ADLs. The MDS revealed the resident required substantial/maximal assistance (resident performs part of the activity, staff provide more than half the effort) with tasks such as dressing (putting on and removing clothing) and hygiene (personal cleanliness such as bathing and grooming). The MDS revealed the resident required assistance with mobility due to weakness and contractures, impacting his ability to safely perform daily tasks independently.Record review of Resident #29's care plan dated 04/01/2026 revealed the resident had conditions including hemiplegia and contractures which required assistance with ADLs. The care plan included interventions for staff to assist the resident with ADLs and repositioning every two hours. The record revealed that due to the resident's limited mobility and contractures, staff assistance was required to maintain proper hygiene and prevent complications. The care plan further indicated that staff were responsible for monitoring the resident's condition and providing necessary assistance with personal care needs, which would include hygiene-related tasks such as nail care (trimming fingernails to prevent injury and infection).Record review of #57's admission record dated 04/13/2026 revealed an [AGE] year-old female with an original admission date of 12/12/2024 and a readmission date of 08/01/2025.Record review Resident #57's history and physical dated 02/06/2026 revealed a diagnosis of unspecified osteoarthritis (joint cartilage degeneration, pain and stiffness).Record review of Resident # 57's quarterly MDS dated [DATE] revealed section gg functional abilities coded Resident # 57 as 09 for personal hygiene meaning the activity was not attempted prior to the current illness, exacerbation or injury.Record review of Resident #57's care plan revealed Resident #57 has an ADL self care performance deficit related to Alzheimer's, history of falls and limited mobility. Interventions included checking nail length and trim and clean on bath day and as necessary.An observation on 04/12/2026 at 11:26 am revealed Resident #57 with fingernails about one centimeter in length on bilateral hands. Resident was unable to voice if she wanted fingernails trimmed or not.Resident # 93Record review of Resident #93's admission record dated 04/14/2026 revealed a [AGE] year old female with an admission date of 09/16/2025.Record review of Resident #93's history and physical dated 02/06/2026 revealed a diagnosis of a cerebrovascular accident with residual left sided weakness (neurological impairment caused by (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	damage to the right hemisphere of the brain, resulting in lasting weakness).Record review of Resident # 93's quarterly MDS assessment dated [DATE] revealed a BIMs score of 12. Section gg coded Resident #93 as 09 for personal hygiene meaning the activity was not attempted prior to the current illness, exacerbation or injury.Record review of Resident # 93's care plan revealed Resident #93 had an ADL self care performance deficit related to a history of cerebral infarction with left hemiparesis/ hemiplegia, contractures, lack of coordination. Interventions revealed the resident required one staff participation with personal hygiene and oral care.An observation and interview on 04/12/2026 at 11:13 AM revealed Resident # 29's fingernails on both hands were about one and a half centimeters long with dark and yellow debris under his fingernails. Resident # 29's left hand was contracted, and his fingernails were touching his palm. Resident #29 stated he did not like his fingernails long and he had requested the facility's staff to trim them but he had not been assisted as of 04/12/2026. An observation and interview on 04/12/2026 at 11:17 am revealed Resident # 93's fingernails on right hand were about a centimeter long with dark debris under and on the nails. Toes nails on bilateral feet were observed to be about 1.5 centimeters long. Resident #93 stated that she would like her nails trimmed and that she had not mentioned this to the facility, but no one had asked her if she would have liked them trimmed.During an interview on 04/13/2026 at 2:05 PM with CNA A, she stated that it was the responsibility of CNAs to ensure fingernails were maintained appropriately. CNA A emphasized that failure to trim Resident #29's fingernails could have resulted in the resident scratching himself, leading to cuts and potential infection. She stated that due to Resident #29's contractures, untrimmed nails could have dug into the skin, increasing the likelihood of injury, skin tears, bleeding, and infection.During an interview on 04/13/2026 at 2:50 PM with LVN B, she stated that all direct care staff were responsible for routinely assessing and maintaining residents' fingernails. She stated it was not acceptable for Resident #29 to have long fingernails, especially considering his contractures, as this could have caused the nails to press into his skin, resulting in bleeding, skin tears, and possible infection. During an interview on 04/13/2026 at 3:16 PM with CNA C, she stated that CNAs were responsible for checking residents' fingernails during routine care, including showers, and ensuring they were properly trimmed. She stated that failure to trim Resident #29's fingernails could have resulted in skin tears, bleeding, and infection. During an interview on 04/14/2026 at 11:43 AM with the PTA, she stated that maintaining trimmed and clean fingernails was essential in preventing injuries, particularly for residents with contractures such as Resident #29. She stated that long fingernails were not acceptable, as they could have dug into the resident's hand, leading to lacerations, bleeding, and potential infection. During an interview on 04/14/2026 at 12:47 PM with LVN D, he stated that both finger nails and toe nails were trimmed as needed. He stated that podiatrist visited the facility every 3 months. He stated that it was the responsibility of both nurses and CNAs to ensure residents fingernails were clean and trimmed. He stated that CNAs and nurses can cut finger nails. CNAs were able to cut toe nails and fingernails if they were not diabetic. He stated residents with long fingernails and toe nails could potentially hurt themselves by scratching themselves or breaking the skin. During an interview on 04/14/2026 at 1:33 PM with the DON, she stated nails were trimmed as needed. She stataed podiatrist came to facility quarterly. She stated that if needed the nurses and CNAs were able to cut the nails. She stated that if residents were not diabetic the CNAS were able to cut fingernails. She stated that a possible risk would be residents scratching themselves causing skin tears and bacteria to enter the wound, long toe nails could get caught in socks and hurt the resident. She stated that it was everyone's responsibility to ensure residents nails were clean and trimmed. During an interview on 04/14/2026 at 1:46 PM with the Administrator, she stated that both the charge nurse and CNAs were responsible for ensuring residents' fingernails were monitored and maintained. She stated that failure to do so could have resulted in skin tears, bleeding, and infection. The Administrator stated that all members of the IDT, including activities staff, were expected to observe and communicate any concerns or assist in ensuring residents' needs were met. Record review of the Nursing Policy and Procedure Manual, titled (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nail Care, not dated, revealed in part: Nail management is the regular care of the toenails and fingernails to promote cleanliness, and skin integrity of tissues, to prevent infection, and injury from scratching by fingernails or pressure of shoes on toenails. It includes cleansing, trimming, smoothing, and cuticle are and is usually done during the bath. Nails can become thinner and more brittle in the elderly and thicker if peripheral circulation is impaired. Nails are also important in assessment, as changes occur with certain medical conditions, such as clubbing with chronic obstructive pulmonary disease or cardiac disease. Color changes with circulatory or lymphatic impairment and certain drug therapy is common. Ingrown toenails are also common in the elderly. Fungal infections of the toenails, dry, brittle ridges and thickening of the nails all occur in the elderly with some frequency.Goals:Nail care will be performed regularly and safely.The resident will be free from abnormal nail conditions.The resident will be free from infection.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observations, interviews, and record review the facility failed to provide pharmaceutical services that assured the accurate acquiring, receiving, dispensing, safe and secure storage of medications for 3 of 4 medication carts reviewed for medication storage. -The facility failed to ensure LVN F signed off on the Individual Control Record when she administered Morphine on 4/13/26 at 10:00 a.m. This failure could place residents at risk of drug diversion of controlled substances.Finding included:Medication Cart 200 Hall:During an observation and interview on 4/13/26 at 10:49 P.M. with LVN F revealed, during a random check of Narcotic Counts revealed that she had administered Morphine 10 mg/0.2 ml oral syringe at 10:00 a.m. and I forgot to sign the medication as given on the Individual Control Record. She said they had been trained to immediately sign out for controlled substance when removed from the medication cart. During an interview on 4/13/26 at 12:00 p.m. with facility's Compliance Nurse revealed that the licensed staff were just retrained on signing out for controlled substances when a controlled medication is administered, by the licensed nurse administering the medication. Review of the facility's policy undated policy on Medication Administration dated provided by the facility's Nurse revealed: Policy:Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal and record keeping in the facility in accordance with federal and state laws and regulations. Procedure:The Director of Nursing, when applicable, the consultant pharmacist maintains the facility's compliance with federal and state laws and regulations and the handling of controlled medications. Only authorized licensed nursing and pharmacy personnel have access to controlled medications. When a controlled medication is administered, the licensed nurse administering the medication immediately enters all of the following information on the accountability record: Date and time of administration, Amount administered, and signature of the nurse administering the dose, completed after the medication is actually administered.