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	04/01/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement quality of life for two residents (Resident #1 and Resident #2) of six residents who were reviewed for dignity.The facility failed to report Resident #1's allegation of being double briefed on 03/09/26 to HHSC.The facility failed to report Resident #2's allegation of an unnamed nurse stating she did not speak Spanish to Resident #2 and left without meeting her needs or sending other staff to assist when made aware 02/11/26.This failure could place the residents at risk of poor self-esteem and decrease self-worth.Findings included:Record review of Resident #1's face-sheet dated 03/30/26 revealed an [AGE] year-old female with initial admission date 12/12/24, and re-admission date 08/01/25.Record review of Resident #1's Health and Physical dated 02/16/26, revealed a medical history of: Alzheimer's disease (a form of Dementia, a loss of brain function), Diabetes Mellitus II (a chronic condition causing high levels of sugar in the blood), and a history of falls.Record review of Resident #1's Quarterly MDS dated [DATE], revealed the BIMS was not completed as Resident #1 was noted to be rarely/never understood.Record review of Resident #1's progress note dated 03/11/25 by the Social Worker, revealed a Care Plan meeting was held with Resident #1's family member, IDT, SW, and the Treatment Nurse. It read: RP (Responsible Party) showed a picture of [Resident #1] being double briefed. RP mentioned that bed is soiled. Picture showed feces and urine . Treatment Nurse reported no redness, breakdown, peri area [groin area] was good. RP educated that [Resident #1] was a ?heavy wetter.' Nursing team will have in-services regarding no double briefing . Retraining was an intervention. SW asked RP regarding resident safety. RP stated that [Resident #1] does feel safe .Record review of Resident #2's face-sheet dated 04/01/26, revealed an [AGE] year-old female with initial admission date 08/15/25 and re-admission date 03/23/26.Record review of Resident #2's Health and Physical dated 03/18/26 revealed medical history of Acute Kidney Injury (when the kidney suddenly cannot filter the wastes from the blood), and Diabetes Mellitus.Record review of Resident #2's Discharge MDS dated [DATE] revealed no BIMS score.Record review of the facility's Grievances revealed a grievance dated 02/11/2026 regarding an allegation made by Resident #2's family member. The grievance noted Resident #2 alleged an unnamed nurse went into her room the night before to answer Resident #2's call light but allegedly stated no [NAME] (No Spanish), when spoken to by Resident #2, and left without providing assistance or sending another staff to assist.Record review of the facility's In-Service Training: Double Briefing of residents is never allowed, dated 03/09/26, with all staff signatures noted under Attendees. In-service training provided by DON and ADONs.In an interview on 03/31/26 at 9:27 AM with Resident #1's family member, he stated he was present on Saturday 03/07/26 in the morning when he smelled a strong odor of urine and feces from Resident #1. He stated he requested assistance from the nursing staff, and he waited outside while Resident #1 had her brief changed. He stated after some minutes, nursing staff left and the family member went back into Resident #1's room and it still smelled like urine and feces. He stated he requested the nurse on the floor to assist, and it was found that Resident #1 had (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	two briefs on, one brief was soiled with urine and feces. He stated he was unable to recall the staff names but stated there was a meeting with the Social Worker, the Treatment Nurse, and the Administrator, regarding the allegation. He stated it was acknowledged Resident #1 was double briefed in the meeting by the nursing staff and stated it was done because Resident #1 was a heavy wetter. He stated the facility staff provided the solution to have CNA A does not provide Resident #1 care, which he agreed to.In an interview on 03/31/26 at 1:58 PM with CNA B, she stated residents having two briefs on at once was not an acceptable practice. She stated the potential risk to residents for double briefing included skin breakdown. CNA B stated double briefing was a form of Abuse and would be reported to the floor nurse right away if observed on the floor.In an interview on 03/31/26 at 2:35 PM with the Treatment Nurse, he stated leaving a resident unattended or leaving the resident and not meeting their needs was Neglect. He stated he recalled the incident with Resident #1 and he was notified of the family member's allegation that Monday 03/09/26 which the Treatment Nurse completed a skin assessment with no findings or changes of Resident #1's skin status. He stated double briefing was not an acceptable practice because it included the risk of infection or illness, including UTIs or skin breakdown. He stated Resident #1 was unable to communicate what happened, and Resident #1's family member was present and witnessed the incident and made the allegation. In an interview on 03/31/26 at 3:00 PM with CNA C, she stated nursing staff was responsible for changing the residents' briefs per policy, including CNAs. She stated having residents with two briefs on at once was negligence and was to be reported to the nurse on the floor, or the DON, immediately if observed. She stated the risk of residents using two briefs at once was an infection control issue which could cause the residents to become sick.In an interview on 03/31/26 at 4:02 PM with LVN D, she stated staff not answering the call light or not meeting residents' needs and turning off the call light anyway was a form of Abuse and Neglect. She stated that all allegations of abuse and neglect were to be reported to the DON and the Administrator, so an investigation could be conducted. She stated double briefing was not acceptable and was a form of neglect. She stated the risks to residents that had two briefs on at once included potential for skin infections or UTI's.Phone interview attempts were made on 04/01/26 at 2:20 PM, 3:34 PM, and 3:56 PM to CNA A, with no answer or call back to the State Investigator before exit. In an interview on 04/01/26 at 11:06 AM with RN E, he stated not changing residents' briefs was abuse. She stated placing two briefs on a resident at the same time was not acceptable and was a dignity issue. She stated double briefing placed residents at risk for skin impairment issues, and it was to be reported to the DON right away.In an interview on 04/01/26 at 02:05 PM with the DON, she stated she was out on personal leave during the allegation of Resident #2. She stated the facility staff were expected to report all allegations of Abuse and Neglect to the Administrator immediately. She stated that allegations made by Resident #1's and Resident #2's family members were allegations of Abuse or Neglect, and they warranted for an internal investigation. She stated there was no written documentation of investigations being conducted for either resident's allegations. She stated the purpose of investigating allegations of Abuse or Neglect was for the safety of the residents and to prevent harm to them. She stated herself as the DON, and the Administrator, were responsible for investigating allegations of abuse and neglect. She stated double briefing was not an acceptable practice and was a form of abuse and neglect. The DON stated the risk of double briefing was skin breakdown from excessive moisture and placed a dignity issue. She stated she was informed by the ADON of Resident #1's family member's allegation and knew CNA A was in-serviced for double briefing. She stated CNA A was not suspended for the allegation regarding Resident #1. The DON stated there was no suspension of any staff for Resident #2's grievance. She stated the Administrator was responsible for reporting all allegations of Abuse, Neglect, and Exploitation, to the State HHSC.In a phone interview on 04/01/26 at 2:30 PM with RN F, she stated she was familiar with Resident #2 but not able to recall any details about her shift on 02/11/26. She denied being aware or being reported concerns regarding Resident #2's allegation. She stated call lights were to be turned off when needs were met.In an interview on 04/01/26 at 2:43 (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PM with the Administrator, she stated double briefing was not acceptable and there was no rationale for the practice. She stated she recalled the meeting with Resident #1's family member and other staff present, regarding the double brief allegation. The Administrator stated that a skin assessment was completed by the Treatment Nurse on 03/09/26 and there were no changes or concerns identified in Resident #1's skin. She stated CNA A was in-serviced regarding the allegation but was not suspended. The Administrator stated there was an internal investigation conducted but did not have it documented to provide to this investigator. She stated that the ADONs, DON, and the Treatment Nurse monitor nursing staff every shift. She stated the risks of double briefing included for residents to experience skin breakdown, infection including UTIs. The Administrator stated Resident #2's grievance was investigated internally but did not have it documented to provide. She stated she spoke with assigned staff during Resident #2's family member allegations, but the staff denied the allegations. She stated no staff was suspended. The Administrator stated the purpose of investigating allegations were to find out accurate information that occurred and verify facts of what happened and the timeline. She stated suspension was done with the purpose of residents feeling safe in the nursing facility and validated with their concerns being addressed. She stated it was done for residents' safety. The Administrator stated she did not believe these allegations were forms of Abuse or Neglect and did not believe they needed to be reported to HHSC.In an interview on 04/01//26 at 3:31 PM with the ADON, she stated she was notified by nursing staff of Resident #1 being double briefed. She stated she worked as the floor nurse over the weekend, but she did not see Resident #1's brief in that incident. The ADON stated she interviewed CNA A, which CNA A admitted to double briefing Resident #1 and apologized. She stated that CNA A was not suspended, and the allegation was not investigated.Record review of the facility's policy Abuse/Neglect with revision date 03/29/2018, read in part: The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation . It continued to read: The Facility will provide and ensure the promotion and protection of resident rights. Under E. Reporting, 3. Facility employees must report all allegations of: abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident property or injury of unknown source to the facility administrator. The facility administrator or designee will report to HHSC all incidents that meet the criteria of provider Letter 19-17 dated 07/10/19. it also stated if the allegation does not involve abuse or serious bodily injury, the report must be made within 24 hours of the allegation.Record review of the Long-Term Care Regulation Provider Letter, provided by the Adminstrator, with revision date 01/22/26, read in part: 2.1 Incidents that Providers Must Report to HHSC: Abuse, Neglect . with the time frame being reporting to HHSC was noted as immediately but not later than 24 hours after the incident or allegation occurs. It also read: Definitions and Examples of ANE and other Reportable Incidents-Neglect: HHSC rules define neglect as, 'the failure to provide for oneself the goods or services, including medical services, that are necessary to avoid physical or emotional harm, pain, or the failure of a caregiver to provide such goods or services.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure that all allegations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source, were reported to the State Survey Agency, for two Residents (Resident #1 and #2) of six residents reviewed for abuse/neglect.The facility failed to report Resident #1's allegation of being double briefed on 03/09/26 to HHSC.The facility failed to report Resident #2's allegation of an unnamed nurse stating she did not speak Spanish to Resident #2 and left without meeting her needs or sending other staff to assist when made aware 02/11/26.This failure could place the 92 residents who reside in the facility at risk of abuse and neglect.Findings included:Record review of Resident #1's face-sheet dated 03/30/26 revealed an [AGE] year-old female with initial admission date 12/12/24, and re-admission date 08/01/25.Record review of Resident #1's Health and Physical dated 02/16/26, revealed a medical history of: Alzheimer's disease (a form of Dementia, a loss of brain function), Diabetes Mellitus II (a chronic condition causing high levels of sugar in the blood), and a history of falls.Record review of Resident #1's Quarterly MDS dated [DATE], revealed the BIMS was not completed as Resident #1 was noted to be rarely/never understood.Record review of Resident #1's progress note dated 03/11/25 by the Social Worker, revealed a Care Plan meeting was held with Resident #1's family member, IDT, SW, and the Treatment Nurse. It read: RP (Responsible Party) showed a picture of [Resident #1] being double briefed. RP mentioned that bed is soiled. Picture showed feces and urine . Treatment Nurse reported no redness, breakdown, peri area [groin area] was good. RP educated that [Resident #1] was a ?heavy wetter.' Nursing team will have in-services regarding no double briefing . Retraining was an intervention. SW asked RP regarding resident safety. RP stated that [Resident #1] does feel safe .Record review of Resident #2's face-sheet dated 04/01/26, revealed an [AGE] year-old female with initial admission date 08/15/25 and re-admission date 03/23/26.Record review of Resident #2's Health and Physical dated 03/18/26 revealed medical history of Acute Kidney Injury (when the kidney suddenly cannot filter the wastes from the blood), and Diabetes Mellitus.Record review of Resident #2's Discharge MDS dated [DATE] revealed no BIMS score.Record review of the facility's Grievances revealed a grievance dated 02/11/2026 regarding an allegation made by Resident #2's family member. The grievance noted Resident #2 alleged an unnamed nurse went into her room the night before to answer Resident #2's call light but allegedly stated no [NAME] (No Spanish), when spoken to by Resident #2, and left without providing assistance or sending another staff to assist.Record review of the facility's In-Service Training: Double Briefing of residents is never allowed, dated 03/09/26, with all staff signatures noted under Attendees. In-service training provided by DON and ADONs.In an interview on 03/31/26 at 9:27 AM with Resident #1's family member, he stated he was present on Saturday 03/07/26 in the morning when he smelled a strong odor of urine and feces from Resident #1. He stated he requested assistance from the nursing staff, and he waited outside while Resident #1 had her brief changed. He stated after some minutes, nursing staff left and the family member went back into Resident #1's room and it still smelled like urine and feces. He stated he requested the nurse on the floor to assist, and it was found that Resident #1 had two briefs on, one brief was soiled with urine and feces. He stated he was unable to recall the staff names but stated there was a meeting with the Social Worker, the Treatment Nurse, and the Administrator, regarding the allegation. He stated it was acknowledged Resident #1 was double briefed in the meeting by the nursing staff and stated it was done because Resident #1 was a heavy wetter. He stated the facility staff provided the solution to have CNA A does not provide Resident #1 care, which he agreed to.In an interview on 03/31/26 at 1:58 PM with CNA B, she stated residents having two briefs on at once was not an acceptable practice. She stated the potential risk to residents for double briefing included skin breakdown. CNA B stated double briefing was a form of Abuse and would be reported to the floor (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nurse right away if observed on the floor.In an interview on 03/31/26 at 2:35 PM with the Treatment Nurse, he stated leaving a resident unattended or leaving the resident and not meeting their needs was Neglect. He stated he recalled the incident with Resident #1 and he was notified of the family member's allegation that Monday 03/09/26 which the Treatment Nurse completed a skin assessment with no findings or changes of Resident #1's skin status. He stated double briefing was not an acceptable practice because it included the risk of infection or illness, including UTIs or skin breakdown. He stated Resident #1 was unable to communicate what happened, and Resident #1's family member was present and witnessed the incident and made the allegation. In an interview on 03/31/26 at 3:00 PM with CNA C, she stated nursing staff was responsible for changing the residents' briefs per policy, including CNAs. She stated having residents with two briefs on at once was negligence and was to be reported to the nurse on the floor, or the DON, immediately if observed. She stated the risk of residents using two briefs at once was an infection control issue which could cause the residents to become sick.In an interview on 03/31/26 at 4:02 PM with LVN D, she stated staff not answering the call light or not meeting residents' needs and turning off the call light anyway was a form of Abuse and Neglect. She stated that all allegations of abuse and neglect were to be reported to the DON and the Administrator, so an investigation could be conducted. She stated double briefing was not acceptable and was a form of neglect. She stated the risks to residents that had two briefs on at once included potential for skin infections or UTI's.Phone interview attempts were made on 04/01/26 at 2:20 PM, 3:34 PM, and 3:56 PM to CNA A, with no answer or call back to the State Investigator before exit. In an interview on 04/01/26 at 11:06 AM with RN E, he stated not changing residents' briefs was abuse. She stated placing two briefs on a resident at the same time was not acceptable and was a dignity issue. She stated double briefing placed residents at risk for skin impairment issues, and it was to be reported to the DON right away.In an interview on 04/01/26 at 02:05 PM with the DON, she stated she was out on personal leave during the allegation of Resident #2. She stated the facility staff were expected to report all allegations of Abuse and Neglect to the Administrator immediately. She stated that allegations made by Resident #1's and Resident #2's family members were allegations of Abuse or Neglect, and they warranted for an internal investigation. She stated there was no written documentation of investigations being conducted for either resident's allegations. She stated the purpose of investigating allegations of Abuse or Neglect was for the safety of the residents and to prevent harm to them. She stated herself as the DON, and the Administrator, were responsible for investigating allegations of abuse and neglect. She stated double briefing was not an acceptable practice and was a form of abuse and neglect. The DON stated the risk of double briefing was skin breakdown from excessive moisture and placed a dignity issue. She stated she was informed by the ADON of Resident #1's family member's allegation and knew CNA A was in-serviced for double briefing. She stated CNA A was not suspended for the allegation regarding Resident #1. The DON stated there was no suspension of any staff for Resident #2's grievance. She stated the Administrator was responsible for reporting all allegations of Abuse, Neglect, and Exploitation, to the State HHSC.In a phone interview on 04/01/26 at 2:30 PM with RN F, she stated she was familiar with Resident #2 but not able to recall any details about her shift on 02/11/26. She denied being aware or being reported concerns regarding Resident #2's allegation. She stated call lights were to be turned off when needs were met.In an interview on 04/01/26 at 2:43 PM with the Administrator, she stated double briefing was not acceptable and there was no rationale for the practice. She stated she recalled the meeting with Resident #1's family member and other staff present, regarding the double brief allegation. The Administrator stated that a skin assessment was completed by the Treatment Nurse on 03/09/26 and there were no changes or concerns identified in Resident #1's skin. She stated CNA A was in-serviced regarding the allegation but was not suspended. The Administrator stated there was an internal investigation conducted but did not have it documented to provide to this investigator. She stated that the ADONs, DON, and the Treatment Nurse monitor nursing staff every shift. She stated the risks of double briefing included for residents to (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	experience skin breakdown, infection including UTIs. The Administrator stated Resident #2's grievance was investigated internally but did not have it documented to provide. She stated she spoke with assigned staff during Resident #2's family member allegations, but the staff denied the allegations. She stated no staff was suspended. The Administrator stated the purpose of investigating allegations were to find out accurate information that occurred and verify facts of what happened and the timeline. She stated suspension was done with the purpose of residents feeling safe in the nursing facility and validated with their concerns being addressed. She stated it was done for residents' safety. The Administrator stated she did not believe these allegations were forms of Abuse or Neglect and did not believe they needed to be reported to HHSC.In an interview on 04/01//26 at 3:31 PM with the ADON, she stated she was notified by nursing staff of Resident #1 being double briefed. She stated she worked as the floor nurse over the weekend, but she did not see Resident #1's brief in that incident. The ADON stated she interviewed CNA A, which CNA A admitted to double briefing Resident #1 and apologized. She stated that CNA A was not suspended, and the allegation was not investigated.Record review of the facility's policy Abuse/Neglect with revision date 03/29/2018, read in part: The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation . It continued to read: The Facility will provide and ensure the promotion and protection of resident rights. Under E. Reporting, 3. Facility employees must report all allegations of: abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident property or injury of unknown source to the facility administrator. The facility administrator or designee will report to HHSC all incidents that meet the criteria of provider Letter 19-17 dated 07/10/19. it also stated if the allegation does not involve abuse or serious bodily injury, the report must be made within 24 hours of the allegation.Record review of the Long-Term Care Regulation Provider Letter, provided by the Adminstrator, with revision date 01/22/26, read in part: 2.1 Incidents that Providers Must Report to HHSC: Abuse, Neglect . with the time frame being reporting to HHSC was noted as immediately but not later than 24 hours after the incident or allegation occurs. It also read: Definitions and Examples of ANE and other Reportable Incidents- Neglect: HHSC rules define neglect as, 'the failure to provide for oneself the goods or services, including medical services, that are necessary to avoid physical or emotional harm, pain, or the failure of a caregiver to provide such goods or services.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for one (Residents #1) of one resident who was provided incontinence care by CNA A observed.CNA A failed to dispose Resident #1's soiled brief after a brief change request and double briefed Resident #1 on 03/07/2026.These failures could affect the residents with incontinence by placing them at risk for the development or worsening of UTIs. The findings include:Record review of Resident #1's face-sheet dated 03/30/26 revealed an [AGE] year-old female with initial admission date 12/12/24, and re-admission date 08/01/25.Record review of Resident #1's Health and Physical dated 02/16/26, revealed a medical history of: Alzheimer's disease (a form of Dementia, a loss of brain function), Diabetes Mellitus II (a chronic condition causing high levels of sugar in the blood), and a history of falls.Record review of Resident #1's Quarterly MDS dated [DATE], revealed BIMS was not completed as Resident #1 was noted to be rarely/never understood.Record review of Resident #1's progress note dated 03/11/25 by the Social Worker, revealed a Care Plan meeting was held with Resident #1's family member, IDT, SW, and the Treatment Nurse. It read: RP (Responsible Party) showed a picture of [Resident #1] being double briefed. RP mentioned that bed is soiled. Picture showed feces and urine . Treatment Nurse reported no redness, breakdown, peri area [groin area] was good. RP educated that [Resident #1] was a ?heavy wetter.' Nursing team will have in-services regarding no double briefing . Retraining was an intervention. SW asked RP regarding resident safety. RP stated that [Resident #1] does feel safe .Record review of the facility's In-Service Training: Double Briefing of residents is never allowed, dated 03/09/26, with all staff signatures noted under Attendees. In-service training provided by DON and ADONs.In an interview on 03/31/26 at 9:27 AM with Resident #1's family member, he stated he was present on Saturday 03/07/26 in the morning when he smelled a strong odor of urine and feces from Resident #1. He stated he requested assistance from the nursing staff, and he waited outside while Resident #1 had her brief changed. He stated after some minutes, nursing staff left and the family member went back into Resident #1's room and it still smelled like urine and feces. He stated he requested the nurse on the floor to assist, and it was founded Resident #1 had two briefs on, one brief was soiled with urine and feces. He stated he was unable to recall the staff names but stated there was a meeting with the Social Worker, the Treatment Nurse, and the Administrator, regarding the allegation. He stated it was acknowledged Resident #1 was double briefed in the meeting by the nursing staff and stated it was done because Resident #1 was a heavy wetter. He stated the facility staff provided the solution to have CNA A does not provide Resident #1 care, which he agreed to.In an interview on 03/31/26 at 1:58 PM with CNA B, she stated residents having two briefs on at once was not an acceptable practice. She stated the potential risk to residents for double briefing included skin breakdown. CNA B stated double briefing was a form of Abuse and would be reported to the floor nurse right away if observed on the floor.In an interview on 03/31/26 at 2:35 PM with the Treatment Nurse, he stated he recalled the incident with Resident #1 and he was notified of the family member's allegation that Monday 03/09/26 which the Treatment Nurse completed a skin assessment with no findings or changes of Resident #1's skin status. He stated double briefing was not an acceptable practice because it included the risk of infection or illness, including UTIs or skin breakdown. He stated Resident #1 was unable to communicate what happened, and Resident #1's family member was present and witnessed the incident and made the allegation. In an interview on 03/31/26 at 3:00 PM with CNA C, she stated nursing staff was responsible for changing the residents' briefs per policy, including CNAs. She stated having residents with two briefs on at once was negligence and was to be reported to the nurse on the floor, or the DON, immediately if observed. She stated the risk of residents using two briefs at once was an (continued on next page)

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	04/01/2026

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	infection control issue which could cause the residents to become sick.In an interview on 03/31/26 at 4:02 PM with LVN D, she stated that all allegations of abuse and neglect were to be reported to the DON and the Administrator, so an investigation could be conducted. She stated double briefing was not acceptable and was a form of neglect. She stated the risks to residents that had two briefs on at once included potential for skin infections or UTI's.In an interview on 04/01/26 at 02:05 PM with the DON, she stated double briefing was not an acceptable practice in the facility. She stated having residents with two briefs on at once could be seen as a form of abuse, neglect, and was a dignity issue. She stated other potential risks of double briefing residents included skin breakdown and infection. She stated the CNAs were responsible for their brief changing skill, which was checked off when nursing staff was hired, and annually by Nursing Supervisors. In an interview on 04/01//26 at 3:31 PM with the ADON, she stated she was notified by nursing staff of Resident #1 being double briefed. She stated she worked as the floor nurse over the weekend, but she did not see Resident #1's brief in that incident. The ADON stated she interviewed CNA A, which CNA A admitted to double briefing Resident #1 and apologized. She stated that CNA A was not suspended, and the allegation was not investigated.Record review of the facility's policy Abuse/Neglect with revision date 03/29/2018, read in part: The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation . It continued to read: The Facility will provide and ensure the promotion and protection of resident rights.Record review of the facility's policy Perineal Care Female, with no date, read in part: Procedural Guidelines- H. Gently wash perineal [referring to the genital and anal area] area . H.c. Continue to wash the rest of the perineal area . H.d. change gloves. H.g. Pat dry the perineal area . H.h. Change gloves. and read, J. Closing steps- J.a. If gloved, remove and discard gloves, wash hands.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 1 of 1 residents (Resident #3) reviewed for incontinent care in that; -CNA B failed to change her gloves after they became contaminated during incontinent care while assisting Resident #3. The failure could place resident's risk for cross contamination and the spread of infection.The findings include:Record review of Resident #3's face-sheet dated 04/01/26 revealed a [AGE] year-old female with admission date 09/28/23.Record review of Resident #3's Quarterly MDS dated [DATE] revealed a BIMS score of 15, indicating Resident #3 was cognitively intact.Record review of Resident #3's Health and Physical dated 10/09/25 revealed a medical history of Muscle wasting and atrophy (loss of muscle mass and strength).Record review of Resident #3's care plan with revision date 01/24/2025, revealed Resident #3 was dependent on ADLs and required toileting/brief change x1 person assist.In an observation on 03/31/26 at 1:40 PM with CNA B revealed she was providing perineal care by using a clean wipe each time cleaning the groin area for Resident #3, and disposing the dirty wipes into the trash can located next to Resident #3's bed. CNA B was observed instructing Resident #3 to assist with rolling to her right side so she could clean Resident #3's buttocks. CNA B was observed wiping buttocks with clean wipes and disposing dirty wipes and soiled brief into the trash can. CNA B was observed using the wipes to clean or wipe her gloved hands and proceeded to throw the wipe into trash can. With the same gloves, CNA B put on Resident #3's new brief and covered Resident #3 with her sheets and blanket. CNA B disposed her dirty gloves into the trash and lowered Resident #3's bed.In an interview on 03/31/26 at 02:10 PM with CNA B, she stated all nursing staff were responsible for performing hand hygiene while providing perineal care during brief changes. She stated it was protocol for staff to wash their hands after they disposed of the dirty brief and wipes, and after disposal of the dirty gloves. She stated hand hygiene was done before putting on new gloves and touching the clean supplies such as the new brief. She stated it was an infection control issue and placed residents at risk of illness. She stated she did not change her gloves after disposing the dirty wipes and the soiled brief. She stated she used a clean wipe to clean her gloves after disposing all the dirty wipes and brief. She stated it was not protocol but she did it because Resident #3 was not that dirty. She stated the Resident #3's clean areas were at risk for being contaminated with her dirty gloves when putting on her new brief.In an interview on 03/31/26 at 04:07 PM with LVN D, she stated nursing staff including the CNAs, were responsible for their perineal care provided to residents. She stated nursing staff was expected to perform hand hygiene after disposing all the dirty supplies and gloves. She stated not washing hands or changing gloves during perineal care placed residents at risk for contamination and illness. She stated nurses were responsible for monitoring CNAs and it was done as needed.In an interview on 04/01/26 at 11:09 AM with RN E, she stated nursing staff were responsible for providing proper perineal care including hand hygiene after disposing of the dirty gloves and before putting on new gloves. She stated it was an infection control issue and not washing hands or changing gloves left an opportunity for contamination and illness. RN E also stated residents would also be at risk for infections such as a UTI.In an interview on 04/01/26 at 2:25 PM with the DON, she stated nursing staff was responsible for performing perineal care per facility protocol, including hand hygiene and changing of gloves. The DON stated it was an infection control issue and not doing hand hygiene protocols included risk to residents of illness or being exposed to bacteria. She stated ADONs and herself as the DON, perform Skill Checkoffs, meaning skills were physically evaluated for protocol compliance. Record review of facility's Infection Control Plan: Overview, with no date, read in part: The facility will establish and maintain an infection control program designed to provide a safe sanitary and comfortable environment and to help prevent the development and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	transmission of disease and infection. It continued to read, Intent- The intent of this policy is to assure that the facility develops, implements, and maintains an infection Prevention and Control Program in order to prevent, recognize, and control, to the extent possible, the onset and spread of infection within the facility. The program will: Implement hand hygiene (hand washing) practices consistent with accepted standards of practice, to reduce the spread of infection.Record review of the facility's policy Perineal Care Female, with no date, read in part: Procedural Guidelines- H. Gently wash perineal [referring to the genital and anal area] area . H.c. Continue to wash the rest of the perineal area . H.d. change gloves. H.g. Pat dry the perineal area . H.h. Change gloves. and read, J. Closing steps- J.a. If gloved, remove and discard gloves, wash hands.