STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455718	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pebble Creek Nursing Center	11608 Scott Simpson Dr El Paso, TX 79936

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45399 Based on interviews and record reviews the facility failed to ensure the resident's had the right to be informed of the risks, and participate in, his or her treatment which included the right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she preferred, for 3 of 20 residents (Resident#29, Resident #46, Resident # 90) reviewed for resident rights. The facility failed to obtain informed consent based on information of the benefits, risks, and options available from Resident #29 prior to administering Lorazepam, an antianxiety medication used to treat anxiety. The facility failed to obtain informed consent based on information of the benefits, risks, and options available from Resident #46 prior to administering Valproic Acid, a mood stabilizer . The facility also failed to obtain informed consent based on information of the benefits, risks, and options available from Resident #90 prior to administering Fluoxetine, an antidepressant used to treat depression. This failure could place residents at risk of receiving medications without their prior knowledge or consent, or that of their responsible party. Findings include: Record review of Record review of Resident #29's face sheet revealed admitted [DATE] with diagnoses of Type 2 Diabetes Mellitus (long term condition where body has trouble controlling blood sugars), quadriplegia (paralysis of all four limbs), dysphagia (difficulty swallowing), ataxia (poor muscle control), dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment) and anxiety (a feeling of worry, nervousness, or unease, typically about an imminent event). She was [AGE] years of age. Record review of Resident #29's quarterly MDS, dated [DATE], indicated she had severely impaired cognition based on her BIMS score of 03 indicating the resident was unable to complete the interview. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #29's care plan dated 4/15/24 indicated, in part: Focus: resident uses anti-anxiety medication related to anxiety disorder and hospice. Goal: The resident will be free of discomfort or adverse reactions related to anti-anxiety therapy. Intervention: Administer medications as ordered by physician. Monitor/document side effects and effectiveness. Record review of Resident #29's medication profile dated 10/8/23 indicated in part: Lorazepam 1 mg/0.5ml, give 0.5ml by mouth every 4 hours as needed for anxiety and restlessness. Record review of Resident #29's clinical records revealed Lorazepam was ordered on 10/8/23. Consent on file was signed 10/13/23 . Record review of Medication administration record revealed Lorazepam were was administered to resident without consent from 10/8/23 to 10/13/23 Record review of Resident #46's face sheet indicated she was [AGE] year-old female admitted to the facility on [DATE] with diagnoses including gastrostomy (an opening into the stomach from the abdominal wall, made surgically for the introduction of food), cerebral infarction (also known as a stroke, refers to damage to tissues in the brain due to a loss of oxygen to the area), heart failure (heart muscle can't pump enough blood to meet the body's needs for blood and oxygen), type 2 diabetes mellitus (A long-term condition in which the body has trouble controlling blood sugar and using it for energy), seizures (a medical condition where you have a temporary, unstoppable surge of electrical activity in your brain). Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #46 had severely impaired cognition based on her BIMS score of 05 indicating the resident was unable to complete the interview. The MDS indicated Resident #46 had an abdominal feeding tube in place. Record review of Resident #46's medication profile dated 6/1/23 indicated in part: Valproic Acid 250 mg/5ml, give 14ml via peg tube three times daily for tremors related to seizures. Record review of Resident #46's clinical records revealed Valproic Acid was ordered on 6/1/23. No consent was found on file. Record review of Medication administration record revealed Valproic Acid were was administered to resident without consent from 6/1/23 to 5/15/24 Record review of Record review of Resident #90's face sheet revealed admitted [DATE] with Type 2 Diabetes (A long-term condition in which the body has trouble controlling blood sugar and using it for energy), depression (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment), hypertension (condition in which the force of the blood against the artery walls is too high). He was [AGE] years of age. Record review of Resident #90's care plan dated 3/4/24 indicated, in part: Focus: resident had impaired cognitive function or impaired thought process. Goal: The resident will maintain current level of cognitive function. Intervention: Administer medications as ordered by physician. Monitor/document side effects and effectiveness. Record review of Resident #90's medication profile dated 05/3/24 indicated in part: (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Fluoxetine 20 MG, give 1 tablet by mouth every morning for depression. Record review of Resident #90's clinical records revealed Fluoxetine was ordered on 5/3/24. Consent on file was signed 5/8/24 . Record review of Medication administration record revealed Fluoxetine were was administered to resident without consent from 5/3/24 to 5/8/24 Interview on 5/15/24 at 2:40 pm, DON stated that she was unable to find a consent for Resident #46 for Valproic Acid. DON called resident's representative to get the consent today. DON stated that she is aware that this resident has been receiving Valproic Acid since 6/1/23. DON stated that she was made aware of rResidents ##29 and #90 not having consents during an audit and was taking measures to improve the consenting process, however it was a challenge. DON stated she planned an in-service for staff on the importance of consenting process. DON stated that the charge nurses were responsible for getting the physician order and then calling family to obtain consent prior to administration of medications. DON stated that she attempted to audit charts monthly but occasionally missed consents. DON stated that she was ultimately responsible to ensure consents were obtained prior to administering medications. DON stated that the consenting process is important because residents have the right to be aware of the benefits and adverse effects of all medications they take. Record review of the facility's policy revised 10/25/17, titled Psychotropic Drugs indicated, in part: A psychotropic drug ifis any drug that affects brain activity associated with mental processes and behavior. These drugs include, but are not limited to, drugs of the following categories: Antipsychotic, antidepressant, anti-anxiety, hypnotic. A psychotropic consent form explains the risks and benefits of psychotropic medications. The resident or their representative must provide documented consent prior to administration of a newly ordered psychotropic medication. Consent for anti-psychotics must be in written form. Phone or verbal consent is not allowed. Permission given by the resident and/or representative does not serve as a sole justification for the medication itself.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49854 Based on observation, interviews and record review the facility failed to ensure residents the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for 1 (Residents #1) of 6 residents reviewed for accommodation of needs: Resident #1's call light was not left within his reach or within sight. This failure could place residents at risk of not having their needs met and a decline in their quality of care and life. Findings included: Resident #1 Record review of Resident #1's face sheet dated 05/16/24, revealed Resident #1 was admitted on [DATE] and that he was a [AGE] year-old male with diagnoses that included unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, lack of coordination, cognitive communication deficit, cardiac arrhythmia (a condition in which the heart beats with an irregular or abnormal rhythm), muscle wasting and atrophy, difficulty in walking, muscle weakness and overactive bladder. Record review of Resident #1's MDS dated [DATE], revealed a BIMS score of 04 out of 15 which indicated his cognition was severely impaired. Indicated that he was totally dependent on one-person staff to aid with showers. Required two-person staff for repositioning and turning in bed every 2 hours and as necessary. Required two-person staff for Hoyer lift and transfer. Required extensive one-person staff assistance with personal hygiene, eating, and dressing. Record review of Resident #1's care plan, initiated on 08/27/2017 and updated on 10/26/2023 indicated, in part, [Resident #1] is High risk for falls r/t Dementia, Psychosis, intellectual disability history of falls. s/p (status/post) fall no injuries. Interventions included be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Record review of Resident #1's physicians orders, dated 10/25/2023, revealed, Clinical Notes: PT/OT for improved mobility and function, walker wheelchair for ambulation, fall precautions in place. During observation on 5/15/2024 at 3:27 pm Resident #1 was lying on his bed asleep. The call light was hanging on the wall where the call light is connected about 3 feet from his bed, and it was not near proximitynot within reach to of Resident #1. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview on 5/15/2024 at 3:50 pm with NA D revealed that the call light was hanging from the wall and not within reach of Resident #1. NA D said that Resident #1 is at fall risk. NA D stated that Resident #1 has a history of falls and that she knew he had fallen the previous month. NA D stated that the call light was not within reach and that Resident #1 would not be able to reach for it if he needed assistance. NA D stated that the call light should always be within reach of the residents. During an interview on 5/16/2024 at 9:46 am, the DON stated that the call light was out of reach for the resident and that if he needed assistance, the call light was not near him. She said that there would be a risk for Resident# 1 not getting the help he needs. She also said that if he would try to get up from bed to get to the call light, he would be at risk of falling from his bed injuring himself. Policies and Procedures were requested at the time of the interview for call lights. On 05/16/24 at 10:15 am DON stated that there were no policies addressing call lights.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30057 45217 Based on interviews, and record reviews, the facility failed to ensure the MDS assessment accurately reflected the resident's status for 1 (Resident #82) of 6 residents reviewed for accuracy of MDS assessments. - The facility failed to ensure that Resident #82's MDS accurately reflected resident's behaviors related to physical behaviors directed toward others. This deficient practice could affect residents who receive MDS assessments and could cause residents not to receive correct care and services. The findings were: Record review of Resident #82's admission record, dated 05/15/2024, revealed Resident #82 was a [AGE] year-old male with admitted [DATE]. Resident diagnoses included cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area) and major depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). Record review of Resident 82's care plan last reviewed 04/17/2024, reads in part that resident had potential to demonstrate physical behaviors by becoming combative towards staff and kicking another resident in the hallway. The care plan was initiated on 08/31/2023 and revised on 04/09/2024. Updated Interventions revised on 03/04/2024, revealed in part: 1:1 monitoring (may request d/c order from MD after 3 days); moved to another room. Review of Resident #82's progress notes dated 03/03/2024 at 14:56 (2:56 p.m.) revealed at approximately 1:40 p.m., staff heard another resident in the hallway scream out and upon entering the hallway the resident said that Resident #82 had kicked her on the right shin and left knee resulting in bruises to the shin and knee. Resident #82 was moved to private room and placed on one-to-one monitoring. Review of Resident #82's quarterly MDS dated [DATE], Section E - Behaviors, revealed physical, or verbal behavioral symptoms directed toward others were not exhibited during seven-day lookback review. During an interview on 05/15/2024 at 2:30 p.m., MDS Coordinator C said she was responsible for Resident #82's MDS. MDS Coordinator C said the seven-day look back performed for the assessment dated [DATE], includes review of all notes and interviews related to the resident. MDS Coordinator C said an incident of physical behavioral symptoms directed towards others was documented on Resident #82's progress notes dated 3/3/2024 and should have been captured during the assessment. MDS Coordinator C said she must have overlooked the information. MDS Coordinator C said the MDS dated [DATE] did not accurately reflect the incident information. MDS Coordinator C said an inaccurate MDS may delay facility actions taken and/or other services. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/16/2024 at 3:10 p.m., the DON said the expectation regarding MDS assessments was that each area that required a look back would accurately capture all pertinent information. The DON said the MDS Coordinators are responsible to ensure accurate MDS assessments are performed. The DON said the risk of inaccurate information could affect resident programming decisions. Review of facility policy Documentation dated 2003, reads in part, Documentation is the recording of all information, both objective and subjective, in the clinical record of an individual resident. It has legal requirements, regarding accuracy and completeness . Goal: The facility will maintain complete and accurate documentation for each resident on all appropriate clinical record sheets. Document completed assessments in a timely manner per policy.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49850 Based on observation, interview, and record review the facility failed to provide necessary services to maintain good grooming and hygiene for a resident who was unable to carry out activities of daily living for 2 residents out of 3 (Resident #45, Resident #40). The facility failed to provide personal hygiene for Resident #45 and facial hair care for Resident #40. This deficient practice placed residents at risk of poor hygiene and decline in residents' self-esteem. Findings included: A. Resident #45 Record review of Resident #45's face sheet dated 05/16/2024 revealed admission on 12/09/2016 and re-admission on 09/29/2020 to the facility. Resident #45 was a [AGE] year-old male diagnosed with UNSPECIFIED DEMENTIA, UNSPECIFIED SEVERITY, WITHOUT BEHAVIORAL Primary DISTURBANCE, PSYCHOTIC DISTURBANCE, MOOD DISTURBANCE, AND ANXIETY. Record review of Resident #45's admission MDS dated [DATE] revealed severe cognitive impairment to be able to make daily decisions based on a BIMS (an assessment used to monitor cognition) score of 07. Resident #45 was diagnosed with non-Alzheimer dementia disease, Traumatic brain injury. Nursing staff will set up or help assist resident for showers. Record review of Resident #45's care plan dated 04/17/2024 revealed he has an ADL Self Care performance some limited mobility with goals to maintain and improve current level of function in personal hygiene. Interventions for bathing; check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. Resident # 45 is resistive to care, refuses to shower/medications. Goals included will cooperate with care through next review date. Interventions included provide resident with opportunities for choice during care provision, leave and return 5-10 minutes later and try again, negotiate, and return on agreed time. Observation on 05/15/2024 at 09:52 AM, revealed Resident #45 to be laying down in bed inclined with the same clothes from yesterday 05/14/2024, unshaved with a foul odor. Resident responded and acknowledged questions. Resident #45 stated he goes to shower around 1:00 or2:00 o'clock. Resident #45 stated he does not like to do activities and does not want to shave. Resident Stated he does shower and is fine with showering. During an interview on 05/15/24 at 10:14 AM CNA J, stated staff they will approach resident #45 once about showering, after that he gets verbally and physically aggressive. Then they just leave him alone until he calms down. If you catch him on a great day he will shower but he does not have a specific preference on staff. CNA J said he just gets aggressive. There are no alternatives offered because he does not like people touching him, so no bed baths are offered. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/15/2024 at 10:25 AM ADON stated the CNAs should ask the resident if he wants to shower or not. His scheduled days are Monday, Wednesday, and Fridays. Bed A gets the morning showers and bed B gets the evenings. ADON said Resident #45 just does not like to shower, and they documented when he refuses. During an interview and Record Review on 05/15/2024 at 03:00 PM RN H stated it is Resident #45's right to not shower. An alternative should be given, though. Documentation was not written down for Resident #45 that he refused to shower this morning . RN H stated he would get someone to try and shower him now and will see if he refuses again. RN H said if he does, they will ask for a sponge bath or a wipe down. RN H stated resident can go up to 10 days or more without showering because he gets aggressive. Nurses are supposed to be documenting on either progress notes that resident refused to shower, or an alternative was given, and on paper from the CNAs, which is located at the nurse's desk in the front in a binder. Interview with CNA J on 05/15/24 at 03:50 PM Stated resident #45 refuses to shower, he will agree to shower about once a week only. CNA J stated she will ask, but if he refuses, she will come back and ask one more time. CNA J stated no alternatives are offered because he does not like anyone seeing him or touching him. CNA J believes that it has been about a week ago that he has showered. Interview on 05/15/24 at 03:23 PM DON Stated for all residents nursing should be documenting on the progress notes the refusal so she is able to create a care plan for the resident. DON said if it is not documented then ADON would not know if patient refused or not. DON confirmed that care plan is in place but there is not documentation on refusal of shower. Behavioral services are being put into place for resident but on his recent one it does not show anything regarding his behaviors in showering. There is a risk of skin infections for the resident if he does not shower. DON stated that for Resident #45 that at this moment there is no documentation or known of any skin infections. Interview on 05/15/24 at 04:34 PM ADON, verified that on PCC they have a task that shows them and gives them the option for them to fill out regarding the showers and there is also a book in the front of the nursing station that the CNA's have to document on there if they refuse or not, and that needs to be filled out on a daily basis. which is monitored by the charge nurses, so they make sure it is signed and kept up to date. herself and then follow up if there is any verbal communication on refusing so many days or any issues, but it has not been brought up to her attention if not it would have been addressed nor has it been documented so she was unaware. The documentation is incomplete it should also be documented on the progress notes what was seen, and the nurses are supposed to let herself or know so they can investigate his refusal, and no one has notified them. It is unknown if the resident has skin infections if nurse is saying he only viewed what he could. Requested policy of facility's Activities Daily Living (ADL) requirements but did not have one. Review of facility's in services regarding showers and bath for all CNAs reflected the last in service was performed on 05/13/2024. B. Resident # 40 Review of resident face sheet dated 05/16/2024 revealed Resident #40 was an [AGE] year-old woman admitted on [DATE]. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #40 had a moderate cognitive impairment for cognitive patterns. Resident was diagnosed with Diabetes. Observation on 05/14/24 at 02:38 PM revealed resident #40 has chin hair. Resident stated she does not want facial hair. Her facial hair was about 3 centimeters long. Resident stated she does not let anyone know but would like it done. During an interview on 05/15/24 at 10:05 AM Resident #40 stated she was showered yesterday, and no one asked her to cut her chin hair. Resident stated she was tired and went back to bed. Was asked if she wanted it cut she said yes since yesterday, but no one asked her. Resident #40 stated I already told someone, but they didn't do it, I don't remember who I told. Observation and interview on 05/16/24 at 08:45 am revealed Resident still has facial hair. She stated no one asked her yesterday when she was showering. She stated she does not like having it and it makes her feel uncomfortable. Interview on 05/16/2024 at 08:44 am, CNA G stated that they are trained to ask residents on the days that they shower if they would like their hair chin to cut. CNA G stated that Resident is very vocal and will let them know that she needs it cut and is unsure why they have not cut it. Usually, Resident is good at letting the staff know to cut it but does not recall anyone mentioning she wanted it cut. Review of facility's policy Grooming Activities revised on 02/01/2007 stated the staff will aid with daily grooming activities such as shaving, individualized grooming activities are offered daily as an enhancement to routine care, not as a replacement of routine morning care.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49854 Based on observations, interviews, and record reviews the facility failed to ensure that the residents environment remains as free of accidents hazards as is possible and each resident receives adequate supervision to prevent accidents for 1 (Resident #2) of 6 residents, and one (room [ROOM NUMBER]) of 5 rooms observed. During observations conducted on 05/14/24 at 9:08 am, the sharps container located in room [ROOM NUMBER] occupied by Resident #2, had two disposable razors exposed and reachable on top of the box. During observations conducted on 05/14/24 at 10:24 am, the sharps container located in room [ROOM NUMBER] had one syringe exposed and reachable on the top of the box. This failure could place residents at risk of accidents, and potential harm. Findings include: Record review of Resident #2's face sheet dated 05/16/24, revealed Resident #2 was admitted on [DATE] and that he was a [AGE] year-old male with diagnoses that included cerebral infarction due to occlusion or stenosis (abnormal narrowing of a blood vessel or other tubular organ or structure such as canals) of small artery, dementia in other diseases classified elsewhere, unspecified severity with anxiety, alcohol abuse with other alcohol-induced disorder, essential (primary) hypertension, muscle wasting and atrophy, not elsewhere classified, unspecified site, difficulty walking, lack of coordination, cognitive communication deficit, delusional disorders, major depressive disorder, recurrent, unspecified and anxiety disorder unspecified. Record review of Resident #2's MDS dated [DATE], revealed a BIMS score of 06 out of 15 which indicated his cognitive status was severely impaired. Review of section G reveled activities of daily requiring substantial/maximal assistance (from nursing staff) with personal hygiene, showering, dressing. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #2's care plan, initiated on 09/29/2023 and updated on 02/14/2024 indicated, in part, [Resident #2] Resident #2 attempts to get out of bed, attempts to self-toilet without calling for assistance, wander into offices. It mentions that staff need to ensure resident #2 is wearing appropriate footwear when ambulating or mobilizing, keep furniture in locked position, keep Resident# 2 close to nurses' station at times when he is restless. Resident# 2 needs a safe environment with: (Specify: even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, the bed in low position at night; handrails on walls, personal items within reach), needs activities that minimize the potential for falls while providing diversion and distraction is at risk for wandering. It states that Resident# 2 is disoriented to place, impaired safety awareness. Resident# 2 exit seek and likes to go into other residents' rooms. States that staff needs to stop Resident# 2 from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Staff needs to identify pattern of wandering: Is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise?. Care Plan states there is risk of harm to self and others. Staff is to Monitor/record occurrence of target behavior symptoms (Specify: pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others. etc.) and document per facility protocol. Resident# 2 is taking Anti-anxiety medications which are associated with an increased risk of confusion, amnesia, loss of balance, and cognitive impairment that looks like dementia, falls, broken hips and legs. Monitor (FREQ) for safety. Resident #2 requires anti-psychotic medications r/t Delusional Disorder, experiences audio and visual hallucinations. During observation and interview on 5/15/2024 at 3:30 pm with LVN E revealed that Resident #2 gets assistance with shaving, and she explained that the procedure for disposing of razor blades is to deposit them into the sharps container when disposing of them. She said that they need to be all the way in. She said that if Resident #2 gets assistance in shaving inside his room, it is acceptable to dispose of the razor blades in the sharp's container located inside his room. After LVN E observed the pictures of the razors and the syringe being on top of the box and exposed, she stated that there was a risk for Resident #2 to reach into the box and cut himself with the razors since he does like to ambulate and take items that he sees in his room or that he will wander into other residents' rooms and will take items with him. LVN E said that in the facility there are other residents with the same wandering behavior and will go into other residents' rooms and go through their belongings and take items with them. LVN E said that the razors and syringe being exposed were also a risk to any staff member who touches the sharps' container box and is not paying attention. LVN E said staff could cut or prick themselves with the exposed razors or needles. During observation and interview on 5/15/2024 at 3:50 pm with NA D revealed that the procedure to dispose of razors, is to put them in the container and to push them inside. She was shown the picture with the razors exposed on the top of the container and NA D stated that the razors and syringe being on the top and exposed posted a risk to the residents and staff members and that they could cut themselves with them if they didn't see them. NA D also said that there could be contamination or pathogens. NA D said that Resident #2 along with other residents in the facility, tend to wander and get into each other's rooms and take items with them. NA D said that there was a risk for the residents to go through the sharp's disposal box and injure themselves. (continued on next page)

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Pebble Creek Nursing Center	11608 Scott Simpson Dr El Paso, TX 79936

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observation and interview on 05/16/24 at 9:46 am Interview to DON, she stated that the aides can shave Resident #2 in his bathroom. DON said that to dispose of the used razors, the staff needs to dispose of them by putting them inside the sharp's disposal unit in the room. The same is done for syringes with medications. Upon observation of the pictures of the sharp disposal boxes, she stated that the razors and the syringe not being all the way inside the box and being exposed, constituted a risk for the residents and the staff by potentially cutting or pricking anyone who could reach and touch the box. DON said that Resident #2 and other residents in the facility, display a wandering behavior and they go into each other's rooms and sometimes they take items with them. Record review of a facility provided policy titled, Discarding of Sharps dated 2003, revealed the following. Purpose: To minimize the risk of injuries related to handling of sharps and the risk of transmission of blood-borne disease. Policy: sharps will be placed intact into sharps containers immediately after use. Personnel will not carry used sharps into common areas. Definitions: Sharps. All disposable needles, syringes and scalpel blades including IV catheters butterflies etc. Any other disposable equipment which potentially could puncture the skin during the normal use, such as disposable razors, etcetera. Procedure: Place used sharps, intact, into sharps container.

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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** 49850 During observation, interview, and record review the facility failed to ensure residents with urinary incontinence received appropriate treatment and services to prevent urinary tract infections for 1 resident 1 (Resident #39). Resident #39's indwelling catheter tubing was laying on the floor. The facility failed to ensure Resident #39's subpubic catheter was properly secured . This failure placed resident at an increased risk of a Urinary Tract infection. The Findings included: Review of Resident #39's face sheet revealed an [AGE] year-old woman, who was admitted into the facility on [DATE]. Record review of Resident #39's history and physical dated 01/16/2023 revealed diagnoses of UTI (urinary tract infection), Alzheimer's, Dementia, Diabetes, Gross Hematuria (Blood in the urine). Record review of Resident #39's MDS dated [DATE] revealed no information regarding resident's daily decision making, or functional abilities and goals. Record review of Resident #39's care plan dated 04/03/2024 revealed she has an Indwelling catheter with a goal of will be/remain free from catheter related trauma, and will show no signs of urinary infection, with interventions of Tubing to remain, and maintain the drainage bag off the floor, include monitor/record/report to health care provider for S/S of UTI. Record review of Resident #39's physician order dated 05/01/2024 revealed to provide catheter care every shift, and catheter to drain via gravity. During an observation and interview on 05/16/2024 at 9:58 am Observed the catheter bag laying on the floor on the right side of the bed with blue privacy bag. CNA G stated resident catheter was okay being on the floor since it had the blue bag over it. CNA G reassured that nothing was wrong with the catheter bag since the bag is not actually touching the floor; the blue bag (privacy bag) is. During an observation and interview on 05/16/2024 at 10:32 am, the catheter bag was still laying on the floor . RN H was called and stated the bag should be located below the bladder, and specified it was since her bed was to be low. RN H addressed that the bag could be moved more up so it would not lay right on the floor. RN H secured bag properly on the bed and bag was positioned correctly where it was not laying right on the floor, after it was questioned. RN H addressed that the catheter bag could have torn the way it was laying on the floor and addressed that the bag should not be touching the floor as it is an infection control risk. RN H addressed it is the responsibility of the CNA's and RNs to make sure the bag is not laying on the floor. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/16/2024 at 02:45 PM DON was showed a picture of how the catheter bag was laying on the floor. DON stated it should not be on the floor as that increases the risk of infection, UTI, and Sepsis (Chemicals that are released in the bloodstream to fight an infection trigger inflammation throughout the body). DON Addressed that it is the responsibility of the CNA's and Nurses, at every shift change of the bag. Record review of policy Catheter Care dated 02/13/2007 revealed on general guidelines for a catheter to make sure the catheter tubing and drainage bag are kept off the floor.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30057 Based on observation, interview and record review, the facility failed to ensure nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments and described in the plan of care for 1 of 3 (Resident #14) residents reviewed for care, in that: CNA A changed Resident #14's colostomy bag and wafer without being trained on how to perform the procedure. (A colostomy wafer is a plastic ring that adheres to the skin around the stoma which is an opening in the stomach and connects to an ostomy bag. The wafer, also known as a flange, baseplate, or skin barrier, is designed to protect the skin from the stool that passes through the stoma. The ostomy bag collects the stool and can be detached from the wafer for disposal or cleaning).(An ostomy is a surgical procedure that creates an opening in your abdominal wall. This opening goes from an area inside your body to the outside, usually through your abdominal muscles and skin. Ostomy surgery creates a new way for waste to leave your body.) These failures could place residents at risk for not receiving nursing services by adequately trained nursing staff and could result in a decline in health and infection. Findings include: Record review of Resident #14's admission record dated 05/15/2024 indicated she was admitted to the facility on [DATE] with diagnoses of presence of colostomy and Parkinson's disease. She was [AGE] years of age. Record review of Resident #14's order summary report with active orders as of: 05/15/2024 indicated in part: Apply Colostomy wafer. Change colostomy bag every 8 hours as needed. Cleanse colostomy stoma. Empty colostomy bag every 8 hours as needed. order date 03/28/2024. Record review of Resident #14's care plan dated 05/01/24 indicated in part: Focus: Resident has an ostomy. Goal: Resident will not have any complications related to ostomy status. Interventions: Notify the physician of any noted signs and symptoms of infection to ostomy, unrelieved pain to ostomy, unresolved changes in feces(constipation/diarrhea), Perform ostomy care as ordered. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 05/14/24 at 10:30 AM CNA A was observed providing colostomy care for Resident #14. CNA A said she had noticed the colostomy bag was too full so she decided to remove it and apply a new one. The CNA was cleansing the area around the colostomy stoma with some alcohol prep wipes as she had already removed the colostomy bag along with the wafer part. CNA A said she had not told the nurse the colostomy bag was full, she just noticed it was too full and decided to change it herself. CNA A then proceeded to cleanse the area around the colostomy stoma and then called out for the nurse as she needed some scissors to cut the wafer to size. At this time ADON B entered the room and cut the wafer to size. The ADON asked CNA A if she had already applied the sure-prep (sticky substance to make the skin around tacky) around the stoma to which the CNA did not know what that was. The ADON went and got some sure-prep and also had the charge nurse RN F come in and assess the colostomy stoma. Both RN F and ADON B then left the room and CNA A proceeded to apply the colostomy on the resident without the nurses being present. During an interview on 05/14/24 at 10:54 AM with RN F said as far as he knew the CNA's were allowed to change the colostomy bags to include the wafers. During an interview on 05/14/24 at 10:58 AM with the DON said only the nurses were expected to change the colostomy bags and wafers. The DON said the CNA's could empty the colostomy bags but not change the wafer as they had not been trained to do that. The DON said if the CNA's changed the colostomy bag and wafer they could do it incorrectly and not install it properly. During an interview on 05/14/24 at 11:09 AM with CNA A said she did not normally change the colostomy bag for Resident #14. CNA A said she noticed that the colostomy bag was too full so she decided to change it herself. CNA A said this was the first time she had changed the bag on her own. CNA A said changing the colostomy bag could lead to complications since she was not trained to do that but she did not think about that. CNA A said she did not think to tell the nurse that the colostomy bag was too full. During an interview on 05/14/24 at 2:30 PM ADON B said she believed the CNA's could actually change the colostomy bags but not the wafer. The ADON said she now knew that the CNA's were not supposed to be performing the colostomy care at all and she should have not allowed CNA A to perform the care. During an interview on 05/16/24 at 4:24 PM the Administrator was made aware of the observation regarding colostomy care performed by CNA A. The Administrator said he was not sure as what to say as he did not know if the CNAs were allowed to perform colostomy care. The Administrator said he would look into the issue. Record review of the facility's coaching form dated 05/14/24 and provided by the DON indicated in part: ADON observed and permitted CNA A to continue changing colostomy wafer. ADON educated on policy. Record review of the facility's coaching form dated 05/14/24 and provided by the DON indicated in part: CNA A changed colostomy wafer. CNA A to inform nurse when wafer needs changing. Record review of the facility's undated document titled CNA proficiency audit did not indicate CNAs were trained on colostomy care. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During record review of the facility's document titled Ostomy Care - Nursing policy and procedure manual 2003 indicated in part: Goals. The resident will maintain continuous or intermittent drainage via bowel diversion without complications. The resident will be maintaining optimal skin integrity at stoma site. If the appliance is to be changed remove the belt if one is worn. Gently lift the faceplate or wafer part of the appliance while pushing down and away from the stoma. Cleanse the stoma with warm water and a soft cloth. Dispose of supplies using universal precautions, clean hands, document I & O perform appliance application. Put on gloves add deodorant to pouch if needed and place pinhole in the top of the bag to allow gas to escape. Measure the stoma and cut the proper size hole in the wafer or disc. The precut wafer may also be used once size is determined. Discard of used supplies according to universal precautions. Perform hand washing document I & O. (I = Input and O = output).

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 45399 Based on observation, interview, and record review the facility failed to store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to medications in medication cart 1 of 4 reviewed for label and storage of drugs and biologicals. The facility failed to ensure medication cart #1 was locked when unattended. The facility failed to ensure discontinued medication was locked in medication rooms. This failure could place residents at risk of having access to unauthorized medications and/or lead to possible harm or drug diversions. Findings included: During an observation and interview on 05/14/24 at 11:00am the medication cart #1 was left unattended and unlocked by LVN E. LVN E failed to lock medication cart #1 as she walked away from the medication cart to administer insulin. Medication cart #1 was unattended from 11:05 am to 11:13 am until she noticed and locked the cart. During an interview on 5/14/24 at 11:15 am LVN E stated that she must have overlooked the unlocked cart. LVN E stated that she was aware that medication carts should be locked when unattended to avoid people getting into it that should not have access. During an interview on 05/16/24 at 11:30 am DON stated that her expectation was that all medication carts were locked when unattended. DON stated that there was a recent in-service regarding medication carts, and she even sent out a text this morning reminding everyone to keep medication carts locked. DON stated that she is disappointed that staff do not comply. Review of the facility's policy, titled Medication Carts, dated 2003, reflected: 1. The medication rooms carts shall be maintained by the facility. 2. The carts are to be locked when not in use or under the direct supervision of the designated nurse. 3. Carts must be secured.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49850 Based on observation, interviews, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for Food safety. The facility failed to close and seal food and seasonings, dispose of expired foods, and maintain a vent free of dust build up. This failure could affect residents by placing them at risk of food borne illness. Findings include: Observation and interview on [DATE] at 08:07am with dietary staff L. Observed the Cream of Tartar, Salt, and Dill weed seasonings are all opened. Dietary staff L stated they should not be opened and closed them correctly. Observation on [DATE] at 09:09 am: inside the dry storage room they had about 6 bags of expired instant pudding that was dated February 22, 2024. Observation on [DATE] at 08:59 am. Inside the walk-in refrigerator there was a cheese bag that was left opened and not sealed correctly. Observation on [DATE] at 11:15 am: Dietary staff K was wearing crocs with the holes open on the side while preparing the puree foods. Observation and interview on [DATE] at 09:14am, observed dust around vent that is right under the tea maker. Dietary manager stated they do not use that tea maker, but the vent should not be like that. Dietary Manager said it is usually cleaned once a week. Interview on [DATE] at 11:30am Dietary manager stated he would remove the instant pudding from dry storage and discard them properly. Observation on [DATE] at 01:34 PM revealed the vent is cleaned and cleared of dust. Interview on [DATE] at 02:27 PM Dietary manager stated the bag of cheese should not have been opened because of the risk of insects can go inside or it can be contaminated. He stated he had already in serviced all his kitchen staff and had let them know during the in-service that they are to close/seal the bags correctly, and it should be put in gallon bags; he understands staff is in rush but that is no excuse. Addressed the crocs being worn in the kitchen, dietary manager stated if they are comfortable and they are non-slip, they are okay. addressed that the holes on top are fine if they are non-slip shoes. asked if there was any danger or risk to her having opened holes stated that she might burn herself if she dropped something but for the most part, he moves all the heavy things, and they are non-slip shoes. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy Dress Code revised on [DATE] stated dietary employees are requiring wearing uniforms or other scrub type clothing, and appropriate footwear. Crocs style shoes may not have holes in the top side of the foot. Inappropriate footwear includes open toe, peep-toe, or any opening on the top of the shoe area, or flip flops

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45399 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 2 of 6 residents reviewed for infection control. LVN E failed to use gown prior to providing care for Resident #46 who is on enhanced barrier precautions. RN F failed to use gown prior to providing care for Resident #74 who is on enhanced barrier precautions. This failure could place residents at risk for cross contamination and the spread of infection. Findings Included: Record review of Resident #46's face sheet indicated she was a [AGE] year old female admitted to the facility on [DATE] with diagnoses including gastrostomy (an opening into the stomach from the abdominal wall, made surgically for the introduction of food), cerebral infarction (also known as a stroke, refers to damage to tissues in the brain due to a loss of oxygen to the area), heart failure (heart muscle can't pump enough blood to meet the body's needs for blood and oxygen), type 2 diabetes mellitus (long term condition where body has trouble controlling blood sugars), seizures (a medical condition where you have a temporary, unstoppable surge of electrical activity in your brain). Record review of the Quarterly MDS dated [DATE] indicated Resident #46 had severely impaired cognition based on her BIMS score of 05 indicating the resident was unable to complete the interview. The MDS indicated Resident #46 had an abdominal feeding tube in place. Record review of the care plan dated 04/17/2024 indicated Resident #46 requires tube feeding related to dysphagia(difficulty swallowing). Goal is that the resident will remain free of side effects or complications related to tube feedings through review date. Insertion site will be free of signs and symptoms of infection through review date. Interventions are to clean insertion site daily as ordered, monitoring for signs and symptoms of infection and report to physician. Care plan indicated Resident #46 is on enhanced precautions. Goal is there will not be any transmission of infection from or to the resident. Interventions are that gloves and gown should be donned if any of the following activities are to occur: linen change, resident hygiene, transfers, dressing, toileting, incontinent care, bed mobility, wound care, enteral feeds, catheter care, trach care, bathing or high contact activity. Record review of Resident #46's physician orders dated 4/20/23 reflected Special instructions: enhanced barrier precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #74's face sheet indicated she was a [AGE] year old female admitted to the facility on [DATE] with diagnoses including gastrostomy (an opening into the stomach from the abdominal wall, made surgically for the introduction of food), dysphagia (difficulty swallowing), cerebral infarction(also known as a stroke, refers to damage to tissues in the brain due to a loss of oxygen to the area), Congestive Obstructive Pulmonary Disease (group of lung diseases that block airflow and make it difficult to breathe), anxiety (a feeling of worry, nervousness, or unease, typically about an imminent event), and swallowing disorder (difficulty swallowing). Record review of the Quarterly MDS dated [DATE] indicated Resident #74 had severely impaired cognition based on her BIMS score of 00 indicating the resident was unable to complete the interview. The MDS indicated Resident #74 had an abdominal feeding tube in place. Record review of the care plan dated 04/20/23 indicated Resident #74 requires tube feeding related to dysphagia(difficulty swallowing). Goal is that the resident will remain free of side effects or complications related to tube feedings through review date. Insertion site will be free of signs and symptoms of infection through review date. Interventions are to clean insertion site daily as ordered, monitoring for signs and symptoms of infection and report to MD. Care plan indicated Resident #74 is on enhanced precautions. Goal is there will not be any transmission of infection from or to the resident. Interventions are that gloves and gown should be donned if any of the following activities are to occur: linen change, resident hygiene, transfers, dressing, toileting, incontinent care, bed mobility, wound care, enteral feeds, catheter care, trach care, bathing or high contact activity. Record review of Resident #74's physician orders dated 4/20/23 Special instructions: enhanced barrier precautions. During observation of medication pass on 5/14/24 at 11:00 am LVN E entered Resident #46's room and put on gloves and checked resident's blood sugar. LVN #46 then took off gloves and disposed of them and left the room to get insulin pen. LVN E obtained and prepped insulin pen from the medication cart that is located 2 doors down the hall. LVN E returned to Resident #46's room and informed resident that she was going to administer insulin. LVN E put on gloves and pulled resident's blanket down to expose resident's arm. She then rolled up resident's sleeve and administered insulin via injection to resident's arm. LVN E failed to gown up according to policy that requires all staff and providers to use protective gown when providing care to residents on enhanced precautions. During observation of medication pass on 5/14/24 at 9:26 am RN F parked the medication cart at the entrance to the door of Resident #74. RN F sanitized hands and put on clean gloves. Resident #74 was in wheelchair and came behind nurse mumbling and grabbing RN F's pant leg. RN F told her he was preparing her medications. RN F was holding Peg tube in hand. RN F then turned around and tried to unlock the Peg tube, then attached syringe to the Peg tube and added each medication, allowing to enter by gravity, flushed with 30 ml water and locked the Peg tube. RN F failed to gown up according to policy that requires all staff and providers to use protective gown when providing care to residents on enhanced precautions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455718	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pebble Creek Nursing Center	11608 Scott Simpson Dr El Paso, TX 79936

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/15/24 at 02:40 pm LVN E stated that she was under the impression that she only needed to gown up if she was doing wound care. LVN E stated she was unsure why resident was under enhanced precautions. LVN E stated that enhanced precautions are meant to decrease transmission of infection and her failure could lead to infection spreading from one resident to another. During an interview on 5/15/24 at 11:23 am with DON/Infection Preventionist stated that all residents with urinary catheters, enteral feeding tubes and wounds are placed on enhanced barrier precautions. DON stated that these residents have instructions on their doors stating all staff should wear gloves and gowns prior to providing resident care along with a cart of gloves, gowns, and hand sanitizer. Observation made of signage on doors and carts with PPE outside rooms. DON stated that staff should wear gowns and gloves when giving showers, administering medications, and checking blood sugars. DON stated that staff were trained on infection control, PPE use and hand hygiene monthly. DON stated that her expectations are that all staff were following facility policies to prevent the spread of infection. Record review of the facility's policy Enhanced Barrier Precautions revised on 04/01/2024 indicated in part: Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug resistant organisms that employ targeted gown and glove use during high contact resident care activities. EBP are used in conjunction with standard precautions and expand the PPE to donning of gown and gloves during high contact resident care activities. EBP are indicated for resident with any of the following: wound end dwelling medical device such as central line, urinary catheters, feeding tube, and tracheostomies. PPE 4 enhanced barrier precautions is only necessary when performing high contact care activities such as administering medications enterally, Performing wound care, transferring a resident, changing brief or assisting with toileting, turning and repositioning resident in bed, dressing a resident, bathing or showering a resident, providing hygiene, changing linen, accessing central line, accessing urinary catheter, accessing feeding tube, accessing tracheostomy/ ventilator, or any other high contact activity that includes close bodily contact or coming into contact with indwelling medical device