STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455718	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/20/2024

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

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46998 Based on interviews, and record reviews, the facility failed to ensure all residents were free from abuse for 1 (Resident #2) of 5 residents reviewed for abuse. On 08/01/24, CNA A was providing Perineal Care (cleaning the private areas of residents) to Resident #2. During the peri-care CNA A was observed being verbally and physically abusive, grunting, rough, and aggressive while turning Resident #2. CNA A was observed aggressively positioning Resident #2's legs and arms and aggressively putting on the brief, and Resident #2's bottoms. The following day 08/02/24 Resident #2 was assessed by the nursing staff revealing a 4 cm (a metric unit for the measurement of length of objects and small distances) by 3 cm left lower leg bruise, 7 cm by 4 cm left leg bruise, and 5 cm by 2 cm inguinal (relating to or situated in the region of the groin) area left side bruise. The noncompliance was identified as past non-compliance. The non-compliance began on 08/01/24 and ended 08/02/24 due to the facility having implemented action that corrected it before the investigation began. This failure could place residents at risk of physical harm and impact their psychosocial well-being in areas such as mental anguish, fear, dehumanization, and humiliation. Findings included: Record review of Resident #2's face sheet dated 09/17/24, revealed, admission on 05/14/24 to the facility. Record review of Resident #2's facility history and physical dated 05/15/24, revealed, a [AGE] year-old female diagnosed with Down Syndrome (a condition in which a person has an extra chromosome or an extra piece of a chromosome), Dementia (the loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities), and Seizures (a burst of uncontrolled electrical activity between brain cells). (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455718	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/20/2024
NAME OF PROVIDER OR SUPPLIER Pebble Creek Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0600 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #2's admission MDS dated [DATE], revealed, there was not BIMS score taken to identify Resident #2's cognition to be able to recall or make daily decisions. Resident #2 was dependent (nursing staff does all the work) for toileting and lower dressing. Resident #2 was substantial/maximal assistance (nursing staff does more then half the effort) for rolling to the left or right while being on the bed. Resident #2 was frequently incontinent. Record review of Resident #2's care plan dated 05/14/24, revealed the following care areas: *Bladder incontinence - monitor/document/report change in behavior. *Bowel incontinence - see care plans on mobility, ADLs, Cognitive Deficit, Communication. *Impaired Cognitive function/dementia - monitor/document/report changes in cognitive functions, decision making ability, general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status. *ADLs for bed mobility - one staff assistance, for toileting was one staff assistance, and dressing was one staff assistance. Record review of Resident #2's Care plan dated 06/11/24 revealed the resident had the potential to demonstrate physical behaviors and poor impulse control. Interventions were to notify the charge nurse of any physically abusive behavior, when agitated engage calmy in conversation, staff to walk calmy away and approach later. Record review of Resident #2's progress notes by LVN B dated 08/01/24, revealed, Full head to toe assessment done with assistance of CMA. Resident #2 cooperative with assessment. No injuries noted at time of assessment and no pain or discomfort. Resident #2 appears to be stable and in a calm affect. Record review of Resident #2's progress notes by LVN I dated 08/02/24, revealed, It was notified to DON that Resident #2 was found with some bruises. Checked on Resident #2 and found the following bruises: 4cm by 3cm left lower leg bruise, 7cm by 4cm left lower leg bruise, 5cm by 2cm inguinal area left side bruise. Resident #2 denied pain upon touching on the site. Color for all of them was purple. Record review of Resident #2's Progress note by SW dated 08/02/24, revealed, she checked on Resident #2 after the incident and was not in any emotional distress. Record review of Resident #2's Event Note by LVN B dated 08/02/24, revealed, Resident #2 had a cognitive impairment. The Family member reported to LVN B CNA A last night had been really rough with Resident #2. The Family member showed LVN B and then LVN B reported the situation to the DON. Assessed Resident #2 for injuries with CMA. No injuries noted at time of assessment. Record review of Resident #2's police report dated 08/02/24, revealed, Officer C and Officer D were dispatched to the facility in reference to an assault information call. Officers met with DON who advised that one of the nurses (CNA A) for the facility had been seen on video being Rough with one of the residents. DON advised she wanted the incident documented as they had to report it to the Health and Human Services Commission. Photograph were taken of Resident #2 and upload to the case. (continued on next page)

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	455718	A. Building B. Wing	09/20/2024

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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F 0600 Level of Harm - Actual harm Residents Affected - Few	

Record review of the EPPD Detective e-mail dated 09/23/24, revealed, The Officers asked how long CNA A had worked at the facility to which the DON stated for 6 years and there had been no other complaints. The officers asked the DON what happens in the event of a similar situation. The DON advised that the employee was placed on leave pending a further investigation, but due to the videos in this situation, they were able to immediately terminate CNA A. The Officers watched both surveillance videos and observed CNA A using force with Resident #2 in an attempt to change her diaper. In one of the videos CNA A was heard calling Resident #2 an Ingrata which translates to Ungrateful. Officers attempted to speak with Resident #2 but was non-verbal. Photos were taken and all three videos. Officer C observed that Resident #2 had two bruises to the left leg, which are also consistent with Resident #2 striking her leg with her right leg trying to cross her legs. Officer D spoke with family member who did not wish to prosecute. Family member did not wish for any relation to be taken against Resident #2 due to charges being pressed and was satisfied with the action the Administration had taken with CNA A.

Record review of the Video Recordings 210139 dated 08/01/24 provided by the DON not time stamped revealed the following:

CNA A was in Resident #2's room with the curtain closed. CNA A was trying to put on Resident #2's bottoms. Noises are heard as the CNA A turned Resident #2 towards her.

CNA A aggressively pushed Resident #2s left leg down with her right hand and placed her right hand on Resident #2's left knee turning it towards her aggressively.

CNA A used her left hand to aggressively grab Resident #2's left arm/elbow area to Resident #2 towards her.

CNA A used her left hand to grab the top of the residents' brief and her right hand to grab the bottom of the brief and aggressively pulled upwards causing a wedgy like affect but in a vertical way. The brief was pulled so aggressively and high that Resident #2's private area could be seen. The brief was heard as it was stretching.

CNA A used her right hand to move the liner in place and again pulled Resident #2's brief aggressively and Resident #2 made an noise.

CNA A was trying to put on Resident #2's left leg in the pants as Resident #2 was still turned towards CNA A with her head facing upwards.

Resident #2's private area could be seen and Resident #2 extended her left leg and CNA A forcefully pushed Resident #2's right leg down on the bed. CNA A stated (in Spanish) to wait as she puts her right hand on Resident #2's left side knee in an aggressive manner.

Resident #2's left leg curved over her right leg as CNA A grabbed her left leg with her right hand to extend outwards. A thump could be heard as the left leg touches the bed. Resident #2's brief started coming off as the aide was trying to put Resident #2's left leg in her pants. The brief opened exposing the residents' private areas while the aide was trying to put Resident #2's right leg in her pants. As the aide tried to put the resident's leg in her pants, she in an aggressive manner tossed the residents left leg away onto the bed.

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NAME OF PROVIDER OR SUPPLIER Pebble Creek Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0600 Level of Harm - Actual harm Residents Affected - Few	CNA A used her left hand grabbed the residents brief and pulled it outwards in an aggressive manner, CNA A made a grunting noise. The brief tore due to the aggressive pull. CNA A pulled so hard that Resident #2's private area was exposed; she placed the brief over the private area while she went to grab something. CNA A tuned around and tossed part of the brief with her left-hand on the floor. CNA A grabbed a new brief from a drawer without changing her gloves and to open it. Resident #2 was laying with her gray pants up to her knee, having her left leg straight and her right leg curved over her left leg. CNA A went over to the resident with the new brief and forcefully extended the resident's right leg down into the bed making an aggressive noise. Resident #2 bent her right leg and the aide aggressively extended it outwards using both hands. CNA A grabbed Resident #2's left leg thigh with both hands to reposition Resident #2 aggressively and yelled hey at the resident as she forcefully turned Resident #2. CNA A with her right hand grabbed the white bedliner and with her left-hand grabbed Resident #2's shoulder to turn Resident #2 towards her. CNA A yanked Resident #2 two times and then placed her left hand behind the residents back. CNA A removed the old brief and tried to place the new brief by extending Resident #2's left leg out as Resident #2 remained positioned on her right-side. Resident #2's rear was exposed. CNA A used her left hand placing it on Resident #2's rear and with her right hand tried to place the white liner and the new brief. CNA A laid Resident #2 on her back and again extended Resident #2's left leg outwards in an aggressive manner opening Resident #2's legs exposing her private parts as she puts on the brief. The aide aggressively pulled out the old brief as the strings were heard snapping and dropped onto the fall mat. CNA A tried to turn Resident #2 away from her by leaning on the resident and placing her right forearm and elbow on Resident #2's hip/right thigh area to turn Resident #2. CNA A stopped leaning on the resident but to keep Resident #2 from repositioning herself CNA A took her right hand and hit Resident #2's right hip making a slapping sound. CNA A pulled on the brief and a tearing sound was heard. Resident #2 was seen curling her right leg as she tried to turn back over. The aide said, oh shit and turned Resident #2 on her back by pulling her right leg in an aggressive manner. Resident #2's private area was exposed again. CNA A aggressively pulled upwards on the brief and opening it in a fan to try to place it on Resident #2. CNA A grabbed Resident #2's right arm and tossed it upwards away from the brief. Resident #2 curled her legs inwards. The aide aggressively grabbed the resident's right leg and said in Spanish hold on. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	CNA A used her right forearm to move Resident #2's left leg outwards. The aide fastened both sides of the brief and placed her right hand on Resident #2's right thigh in an aggressive manner. At no time during the video did the CNA change gloves. Record review of the Video Recordings 210411 dated 08/01/24 provided by the DON not time stamped revealed the following: CNA A leaned over Resident #2 who was lying on her back in bed. Resident #2 crossed her right leg over her left leg/thigh area with the gray pant still on. CNA A forcibly grabbed Resident #2's right leg to extend it straight and grabbed Resident #2's left foot to put it in the gray pants. The aide pulled the pants over Resident #2's left knee and forcibly extended her left leg. CNA A pulled the pants up to Resident #2's waist and grabbed Resident #2's brief with her right hand and s Resident #2's left shoulder with her left hand to pull her towards her. CNA A moved the white draw sheet and began to pull up the gray pants with her right hand. The aide laid Resident #2 on her back. Resident #2 was turned on her left side and a sound was made once her knees touched the wall next to the bed. CNA A tossed Resident #2's right leg outward and pulled the pants to position them on the resident's waist . CNA A pulled down Resident #2's purple shirt and states in Spanish Ay Esta Ya. (English translation - there you go) Ah Si (English translation- Ah yes). Then says, Ay no. CNA A brings Resident #2 back onto her back and tosses her feet. Lowers the bed and cleans up. Record review of the Video Recordings 210835 dated 08/01/24 provided by the DON not time stamped revealed the following: CNA A threw a brief into the trash can with her right hand as she has Resident #2 on her left side away from her facing the wall. CNA A was holding onto Resident #2's right hip area with her left hand and grabbed for a brief that was open and position towards Resident #2 feet. CNA A told Resident #2 in an aggressive tone to hold on and turn around, like that in Spanish. While she pushed Resident #2 with both hands to stay on her side. CNA A was observed pushing Resident #2's right arm away in a forceful manner. CNA A tried to open the brief and place it on Resident #2. CNA A rolled Resident #2 on her back and put the brief into between the residents' legs. Resident #2's gray pants are placed between her left knee and her right ankle as her right ankle was bent inwards. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	CNA A then stated aver (English translation- lets see). Resident #2 was noted not to be combative and only had her right leg bent towards her left leg. CNA A pulled Resident #2's left wrist with her left hand. CNA A's right hand was seen grabbing the white draw sheet. CNA A stated in Spanish that Resident #2 does not help for anything. Then stated in Spanish to Resident #2 ingrata (Ungrateful). CNA A then says Hijole (geez). CNA A pulled on the brief upward in an aggressive manner The aide put her right arm underneath Resident #2's left leg/thigh area and picking her upwards and tossed her back to the middle of the bed and used her left hand to grab the brief to try to position it better. CNA A said Ah shit and some other word that was not able to make out. CNA A stated to Resident #2 in Spanish Very funny. Resident #2 was not seen laughing. - End of Video. During an observation on 09/17/24 at 11:03 am, Resident #2 was in the dining area and appeared to have no signs of distress. Staff was seen interacting with Resident #2 and again no distress was noted. During an interview on 09/17/24 at 3:17 PM, the DON stated she had received a call in the night on 08/01/24 from LVN A. The DON stated she spoke with the Family Member and was shown the videos. The DON stated it did not look nice. The DON stated the Family Member had told her she did not want CNA A to be taking care of Resident #2. The DON stated once viewing the video she called the Family Member back and told her she was sorry and there was no excuse for what had happened. The DON stated she had suspended CNA A and pushed for her termination. The DON stated a body assessment was conducted by LVN B which there were no injuries noted at that time. The DON stated she told the Family Member that the Administrator was going to report it to state and the Family Member was really thankful. The DON stated they did a skin assessment on all the residents cared for by CNA A. The DON stated no residents came forward stating that CNA A was mean or had done something to them. The DON stated the next day it was observed that Resident #2 had bruises and the local police was notified. The DON stated the local police showed up and took photos of the bruises and conducted some interviews. During an interview on 09/18/24 at 12:05 PM, LVN B stated the Family Member had something she wanted to talk to him about. LVN B stated the Family Member had told him CNA A had been rough with Resident #2, and it would be easier if she showed him. LVN B stated halfway through the video he told her he had seen enough. LVN B stated he reported it to the DON. LVN B stated he felt sad and upset after viewing the video and how Resident #2 was being treated. LVN B stated Resident #2 was being tossed around and pushed by CNA A. LVN B stated it was not appropriate for CNA A to be doing that. LVN B stated it was inappropriate because it was wrong, and it was abuse. LVN B stated CNA A was pushing and hitting Resident #2 during peri-care who had a serve impairment in cognition and was IDD. LVN B stated that sometimes Resident #2 was uncooperative and usually nursing staff would call for help with assistance. LVN B stated it would be expected for nursing staff to be calling for help if they needed the assistance. LVN B stated he assessed Resident #2, and she had no injuries. LVN B stated the facility staff are trained on Abuse, Neglect, and Exploitation as well as Perineal Care. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 09/18/24 at 11:22 AM, the SW stated she was made aware of CNA A mistreating and being verbally abusive to Resident #2. The SW stated the Family Member had a camera install in Resident #2's room and had bought the incident to the nursing staff's attention. The SW stated she did not watch the video as she could not bring herself to watch it. The SW stated she did not watch it because of her love for that population and would not want to see the elderly get mistreated. The SW stated Resident #2 was mistreated. The SW stated that CNA A called Resident a name and was being rather rough when changing her. The SW stated the facility spoke with CNA A to get her side of the story and then reported it to the local police. The SW stated the facility then proceed to terminate CNA A. During an interview on 09/19/24 at 1:39 PM, the Family Member stated she goes at night after work to review the camera and noticed CNA A being rough with Resident #2. The Family Member stated she did not want CNA A to be working with Resident #2 anymore. The Family Member stated Resident #2 needs help with ADLs and was not independent. The Family Member stated she sent the videos to the DON. The Family Member stated the DON had stated that CNA A was terminated, and it was going to be reported to the local police. The Family Member stated on the video it was observed that CNA A was pulling on Resident #2's legs and yelling at her. The Family Member stated CNA A was observed getting very upset with Resident #2. The Family Member stated on one of the videos the CNA A ripped off part of Resident #2's brief. The Family Member stated CNA A got mad that she was going to start over and try to put on another brief. The Family Member stated she had heard her calling Resident #2 Ingrate (English translation- Ungrateful). The Family Member stated it made her feel upset and did not want anybody mistreating Resident #2. During an interview on 09/20/24 at 8:18 AM, with LVN I. LVN I stated the facility was conducting a meeting about what had happened with CNA A, Resident #2, and the local police. LVN I stated the local police came and found bruising on Resident #2 on 08/02/24 on her legs. LVN I stated the DON immediately assessed Resident #2. LVN I stated Resident #2 was not on any Anti-Coagulant. LVN I stated she viewed the video. LVN I stated there were a lot of things that were wrong such as CNA A was talking very rude to Resident #2. LVN I stated also the way that CNA A was turning Resident #2 was also rude while she was providing peri-care. LVN I stated they would not want to turn Resident #2 rough because we have to treat the residents like they are humans and provide perineal care correctly. LVN I stated that they had to be gentle with the residents because there skins are delicate and with Resident #2 she was not able to voice that she was in pain. LVN I stated in the video Resident #2 was making moaning sounds and did not remember if Resident #2 was crying or just moaning. LVN I stated the risk could be bruising and open skin tears. LVN I stated it was abuse. On 09/202/4 at 8:22 AM, the Physician was called, and a call back message was left to call back state. Record review of CNA A's Witness Statement note dated, revealed, I'm very sorry what I did. I don't mean that to happen. I wasn't feeling to well to work. I'm very sorry. I don't know what else to say. I didn't mean to do that. I'm very very sorry. It had never happened before. I never done anything like this before. I didn't mean for this to happen. I am sorry. I been working for so many years I never done this before. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 09/20/24 at 11:10 AM, CNA A stated she was doing her job like always. CNA A stated she had not mistreated a resident in her life. CNA A stated she had told LVN B that she was not mistreating Resident #2. CNA A stated that day she had got a migraine out of nowhere and was in pain and nervous. CNA A stated sometimes that happens and she takes Tylenol or Ibuprofen. CNA A stated she took the Tylenol and went to attend to Resident #2. CNA A stated it did not take affect right away and did not tell the nurse that she needed some time before attending to the residents. CNA A stated Resident #2 had a bowel movement and was going to provide peri-care on her. CNA A stated Resident #2 was heavy and had her feet up and she was trying to put them down. CNA A stated she would put on leg down and then Resident #2 would lift the other leg up. CNA A stated the previous CNAs did not place a white draw sheet underneath Resident #2 and she was lifting her legs up. CNA A stated she was trained on perineal care. CNA A stated she had never mistreated a person. CNA A stated there were only three CNAs and the floor nurse was busy. CNA A stated she did not ask the floor nurses for help nor the CNAs. CNA A stated she felt she did good peri-care and did not mistreat Resident #2. CNA A stated she had changed her gloves three times that night. CNA A stated she was not trained on Abuse, Neglect, and Exploitation. During an interview on 09/20/24 at 1:09 PM, the DON stated the Family members are monitoring Resident #2 on there end and she does spot checks for perineal care 1-2 times a week on random shifts. The DON stated it was to ensure that peri-care was being provided correct and any incorrect perineal care would be corrected on the spot with staff being in-serviced. During an interview on 09/20/24 at 1:17 PM, the Administrator stated on 08/01/24 he was notified of the incident. The Administrator stated CNA A was suspended that day pending the outcome of the investigation. The Administrator stated Resident #2 was assessed by the nursing staff and there were no injuries noted on 08/01/24. The Administrator stated the SW conducted an emotional assessment and with no distress noted. The Administrator stated when the local police arrived and started investigating, they found bruises on Resident #2. The Administrator stated there was a lot of education that was given to the nursing staff such as Abuse and Neglect, Managing Frustration, two-person transferring in-services. The Administrator stated CNA A was terminated. The Administrator stated the Regional Nurse was conducting monitoring on the DON and ADONs who were monitoring the nursing staff with perineal care and on the lookout for burnt out staff to prevent another incident from happening again. The Administrator stated that they also follow their facility protocols with doing background checks, EMR checks, and conducting training. The Administrator stated the reason CNA A was terminated was for abuse of Resident #2. Record review of CNA A's Employee Disciplinary Report dated 08/02/24, revealed, coded Investigation Suspension. CNA A will be placed on investigatory suspension pending an investigation into allegations of abuse. Record review of CNA A's Employee Disciplinary Report (Termination Letter) dated 08/02/24, revealed, coded Discharge. CNA A failed to adhere to the corporate code of conduct. On 08/02/24, CNA A was placed on investigatory suspension pending an investigation into allegations of resident abuse. These allegations were substantiated. CNA A was aware of all polices and procedures via her signature on the employee handbook acknowledgement. CNA A meets criteria for immediate termination. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Record review of CNA A's Official Transcript for training dated 06/07/24, revealed, she was trained on Abuse, Neglect, and Exploitation. Preventing, Recognizing, and Reporting Abuse on 05/24/24. Providing Customer Service on 11/14/23. Record review of CNA A's Proficiency Audit dated 06/11/24, revealed, she was trained with providing Perineal care: female, turns/repositions residents timely/correctly, and Infection Control awareness. Record review of the facility Abuse and Neglect policy 09/09/24, revealed, The resident had the rights to be free from abuse. Residents should not be subjected to abuse by anyone, including but not limited to facility staff and consultants or volunteers, staff of other agencies serving the resident, or other individuals. Abuse - Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse and physical abuse. Verbal Abuse - gestured language that willfully includes disparaging (to criticize someone or something in a way that shows you do not respect or value him, her, or it) and derogatory (expressing a negative or disrespectful connotation, a low opinion, or a lack of respect toward someone or something) terms to residents, or within hearing distance, regardless of their age, ability to comprehend, or disability. Physical Abuse - includes hitting, slapping, pinching, and kicking. Mistreatment - inappropriate treatment or exploitation of a resident. The Administrator was notified on 09/20/24 at 2:20 p.m., that a past non-compliance situation had been identified due to the above failures. The facility implemented the following interventions: Record review of 11 facility Resident Witness Statements dated 08/02/24, revealed, there were no issues with CNA A or negative comments about her. Record review of facility Resident who CNA A had were audited on 08/02/24, revealed, there was only 3 residents with injuries that was unrelated to CNA A. Record review of the facility Actual/Alleged Abuse Monitoring dated 08/02/24 was started on all three shifts. No negative outcomes were noted. Record review of the facility In-services for a 2-person assistance, Abuses & Neglect: Managing Frustration, and Abuse, Neglect, & Exploitation dated 08/02/24 were conducted. During an interview on 09/17/24 at 10:52 AM, with Resident #12, she stated she was treated well by the nursing staff and had no issues with anyone. During an interview on 09/18/24 at 9:31 AM, with Resident #13 stated facility staff have treated her well and had no issues with any of the staff. (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	09/20/2024

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

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 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on09/19/24 at 3:09 PM, with Resident #6 revealed there were no issues with CNA A and deny any injuries During an interview on 09/19/24 at 3:16 PM, with Resident 9revealed there were no issues with CNA A of any kind. and deny any injuries. During an interview on 09/17/24 at 3:17 PM, with the DON, 09/18/24 at 12:05 PM, revealed she was gave and received training on Abuse and Neglect, 2-person transfers, Abuse and Neglect: Managing Frustration. During an interview on 9/19/24 from 12:05PM to 4:11PM with LVNB, LVN E, LVN F, and LVN G revealed they were given and had received training on Abuse and Neglect, 2-person transfers, Abuse and Neglect: Managing Frustration. They stated they stated if they suspected, see, or hear abuse happening they would report it to the Abuse Coordinator who was the Administrator. They stated they had received training on two-person transfers. They stated no resident may be transferred as a one-person transfer and had to be a two-person. They stated they received training on managing frustration and if they felt frustrated to go let management know and or take a break or a breather. During an interview on 09/20/24 from 8:18AM to 1:17PM with CNA H, LVN I, and the administrator revealed they were given and had received training on Abuse and Neglect, 2-person transfers, Abuse and Neglect: Managing Frustration. They stated they had received training on two-person transfers. They stated no resident may be transferred as a one-person transfer and had to be a two-person. They stated they received training on managing frustration and if they felt frustrated to go let management know and or take a break or a breather.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455718	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/20/2024
NAME OF PROVIDER OR SUPPLIER Pebble Creek Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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** 46998 Based on observation, interview, and record review the facility failed to ensure a resident who is unable to carry out activities of daily living receives the necessary services to maintain good grooming and personal and oral hygiene for 2 of 5 (Resident #2, Resident #7) residents reviewed for assistance with peri-care. CNA A failed to provide perineal care with professional standards to ensure Resident #2 was clean, free of contamination. CNA K failed to provide perineal care with professional standards for Resident #7 to ensure they were clean, free of contamination. This failure could place residents who were dependent on staff for ADL care at risk for infections. Findings include: Resident #2 Record review of Resident #2's face sheet dated 09/17/24, revealed, admission on 05/14/24 to the facility. Record review of Resident #2's facility history and physical dated 05/15/24, revealed, a [AGE] year-old female diagnosed with Down Syndrome (a condition in which a person has an extra chromosome or an extra piece of a chromosome), Dementia (the loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities), and Seizures (a burst of uncontrolled electrical activity between brain cells). Record review of Resident #2's admission MDS dated [DATE], revealed, there was not BIMS score taken to identify Resident #2's cognition to be able to recall or make daily decisions. Resident #2 was dependent (nursing staff does all the work) for toileting and lower dressing. Resident #2 was substantial/maximal assistance (nursing staff does more then half the effort) for rolling to the left or right while being on the bed. Resident #2 was frequently incontinent. Record review of Resident #2' care plan dated 05/14/24, revealed the following care areas: *Bladder incontinence - monitor/document/report change in behavior. *Bowel incontinence - see care plans on mobility, ADLs, Cognitive Deficit, Communication. *ADLs for bed mobility was one staff assistance, for toileting was one staff assistance, and dressing was one staff assistance. Record review of the Video Recordings 210139 dated 08/01/24 provided by the DON not time stamped revealed the following: (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA A pulled so hard that Resident #2's private area was exposed; she placed the brief over the private area while she went to grab something. CNA A tuned around and tossed part of the brief with her left-hand on the floor. CNA A grabbed a new brief from a drawer without changing her gloves and to open it. CNA A went over to the resident with the new brief . CNA A yanked Resident #2 two times and then placed her left hand behind the residents back. CNA A removed the old brief and tried to place the new brief by extending Resident #2's left leg out as Resident #2 remained positioned on her right-side. Resident #2's rear was exposed. CNA A used her left hand placing it on Resident #2's rear and with her right hand tried to place the white CNA A used her right forearm to move Resident #2's left leg outwards. The aide fastened both sides of the brief and placed her right hand on Resident #2's right thigh in an aggressive manner. At no time during the video did the CNA change gloves. Record review of the Video Recordings 210835 dated 08/01/24 provided by the DON not time stamped revealed the following: CNA A threw a brief into the trash can with her right hand as she has Resident #2 on her left side away from her facing the wall. CNA A was holding onto Resident #2's right hip area with her left hand and grabbed for a brief that was open and position towards Resident #2 feet. CNA A tried to open the brief and place it on Resident #2. CNA A rolled Resident #2 on her back and put the brief into between the residents' legs. Resident #2's gray pants are placed between her left knee and her right ankle as her right ankle was bent inwards. The aide put her right arm underneath Resident #2's left leg/thigh area and picking her upwards and tossed her back to the middle of the bed and used her left hand to grab the brief to try to position it better. During an interview on 09/17/24 at 3:17 PM, with the DON. The DON stated she was the Infection Preventionist. The DON stated the videos that were provided by the Family Member of Resident #2 on 08/01/24, revealed, CNA A was not seen changing her gloves or using the wipes. The DON stated the reason for changing the gloves was for infection control. The DON stated all nursing staff are trained on perineal care. (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 09/18/24 at 12:05 PM, with LVN B. LVN B stated CNA A conducting perineal care on Resident #2 on 08/01/24 was not proper perineal care. LVN B stated CNA A was being rough with Resident #2 will doing the perineal care and did not change her gloves. LVN B stated Resident #2 was not being wiped right as well. LVN B stated the nursing staff would want to wipe and change the gloves to ensure that the nursing staff was providing good perineal care, cleanliness, and to prevent infection. During an interview on 09/202/4 at 8:18 AM, LVN I stated she viewed the video between CN A and Resident #2 that took place on 08/01/24. LVN I stated while CNA A was changing Resident #2 she throw the diaper on the floor and did not change her gloves. LVN I stated it would be infection control. Record review of CNA A's Official Transcript for training dated 06/07/24, revealed, she was trained on Infection Control and Prevention. Providing customer Service on 11/14/23. Record review of CNA A's Proficiency Audit dated 06/11/24, revealed, she was trained with providing Perineal care: female, turns/repositions residents timely/correctly, and Infection Control awareness. Resident #7 Observation and interview on 09/17/24 at 3:46 PM, with CNA K and Resident #7. CNA K was observed asking Resident #7 where he would like to be changed, resident's bed or in the restroom. CNA K positioned wheelchair next to rail and verbally instructed Resident #7 to lift self by using the rails. Resident #7 was observed standing while holding on to restroom rails. Resident #7 pants were pulled down. CNA K removed and disposed of brief into trashcan. CNA K applied new brief and secured it on resident #7. CNA K walked behind wheelchair and held the wheelchair by handles from behind wheelchair and instructed Resident #7 to sit down. CNA K removed pants bottom and walked into room while Resident #7 stayed in restroom. CNA K opened resident's closet and got new pants for resident while wearing same contaminated gloves. CNA K walked back in restroom and in front of Resident #7 and placed new pant bottoms on. CNA K walked behind wheelchair and positioned resident closer to rails on restroom wall. CNA K held wheelchair by handles and instructed resident to stand. CNA K lifted Resident #7's pant bottoms up. CNA K held wheelchair by wheelchair handles and instructed residents to sit down on wheelchair. CNA K pulled wheelchair with Resident #7 on back into Resident #7's room and positioned him next to his cabinet. CNA K disposed his gloves into trash and went into resident's restroom and performed hand hygiene. CNA K stated hand hygiene was to be performed to prevent contamination. CNA K stated he did not change his gloves nor perform hand hygiene while conducting peri-care. CNA K stated the risk due to lack of hand hygiene can be contamination and infection to resident. Record review of the facility Perineal Care Policy dated 04/25/22, revealed, An incontinent resident of urine and/or bowel should be identified, assessed, and provided appropriate treatment and services to restore as much normal bladder/bowel function as possible. Skin problems associated with incontinence and moisture can range from irritation to increased risk of skin breakdown. Moisture may make the skin more susceptible to damage from friction and shear during repositioning. (continued on next page)

Printed: 12/04/2024
Form Approved OMB
No. 0938-0391

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Purpose - this procedure aims to maintain the resident dignity and self-worth and reduce embarrassment by providing cleanliness and comfort to the resident, preventing infections and skin irritation, and observing the resident's skin condition. Procedure Content: Start- Perform hand hygiene. Don gloves and all other PPE per standard precautions. Limit resident exposure to the perineal area - provide privacy at all times. Gently perform perineal care, wiping from clean urethral (The tube through which urine leaves the body) area, to dirty, rectal area (forms part of the digestive system , sitting in the furthest area of the large intestine), to avoid contaminating the urethral area - Clean to dirty!. Gently perform care to the buttocks and anal area, working from front to back without contaminating the perineal area.