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	01/23/2025

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 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents have reasonable access to and privacy in their use of communication methods. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45217 Based on observation, interview, and record review the facility failed to ensure residents had the right to have reasonable access to the use of a telephone and a place in the facility where calls can be made without being overheard for 1 of 4 (Resident #1) residents reviewed for telephone use. The facility failed to provide a place for Resident #1 to make telephone calls without being overhead. This failure could place residents at risk of conversations being overheard and privacy rights not being respected. The findings included: Record review of Resident #1's Admission Record, dated 01/14/2025, reflected [AGE] year-old female admitted on [DATE]. Record review of Resident # 1's History and Physical dated 10/13/2024, revealed diagnoses of schizoaffective disorder (mental health condition with symptoms of schizophrenia and a mood disorder where person may experience depression, mania and psychosis), anxiety (feeling of worry, nervousness, or unease, typically about an imminent event or something with an uncertain outcome), major depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), and dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities). Record review of Resident # 1's MDS dated [DATE], revealed a BIMS score of 00 indicating the resident was severely impaired cognitively. During an interview on 01/14/2025 at 10:58 a.m., Resident #1 said that she called FM on the phone in the lobby of the facility. Resident #1 said the phone was not cordless and was open for others to listen to her. Resident #1 said she did not feel comfortable speaking privately on the phone as others including staff at the nurses' station could overhear her conversation. Resident #1 said no one had offered her another place to make or take calls in private. Observation on 01/14/2025 at 11:05 a.m., revealed a corded telephone on a table in the open lobby area near the nursing station located between the 200 and 400 halls of the building. (continued on next page)

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

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/14/2025 at 11:24 a.m., LVN D said there was a portable phone in the lobby between the 200 and 400 hall that was lost. LVN D said there was a corded phone in the lobby now. LVN D said Resident #1 received calls from FM and uses the corded phone in the lobby. LVN D said the conversations could be overheard and there was no privacy using the corded phone. LVN D said he had not made any offers to use a phone in a private area or office. LVN D said that he had not spoken with any other facility staff/administration regarding the privacy issue. During an interview on 01/14/2025 at 2:23 p.m., the SW said every Saturday at 10 a.m., Resident #1 was scheduled to face-time FMs using a tablet. The SW said that took place in Resident 1's room and was in private. The SW said when Resident #1 asks to call her FMs, there was a phone at the nursing station or in the living area that Resident #1 uses. The SW said the phone at the nurses' station/lobby was a land line and not in private. The SW said there was a cordless phone in the 100 and 500 hall lobby that she could use and take to her room but does not know if the phone had been offered to Resident #1. During an interview on 01/23/2025 at 11:05 a.m., Resident #1 said she was still using the telephone in the open lobby area without privacy. Resident #1 said she lets the staff know when she was going to use the phone. Resident #1 said she had not been offered any other phone to use in private. Resident #1 said she knows the number she wants to dial and how to use the phone although at times had been assisted by staff to dial the number. Resident #1 said she does not feel secure speaking in the open area and knows that the nurses are close by in the nursing station to possibly overhear her conversation. Resident #1 said it makes her feel like she does not have any privacy. Resident #1 said only on Saturdays was she offered the tablet to make a private face time call with FMs. During an interview on 1/23/2025 at 11:15 a.m., the DON said Resident #1 was using the phone in the lobby routinely. The DON said in the past she had offered Resident #1 to use the phone in an office. The DON said she knows that not all staff may have known to make the offer to Resident #1 of using the phone in a private area. The DON said there was a cordless phone in the lobby between 200 and 400 halls, but the phone went missing. The DON said there was a cordless phone available in the other side of the building to use but did not know if that option had been offered to Resident #1. The DON said the issue was a rights issue and she had started an in-service with staff on resident's right to use a phone privately. Record review of the facility's policy titled Resident Rights, undated, revealed the resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services and a place in the facility where calls can be made without being overheard.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45217 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan that included measurable objectives and time frames to meet a resident's medical and nursing needs and described the services to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 2 (Resident #1 and Resident #8) of 9 residents reviewed for care plans. -The facility failed to follow the comprehensive person-centered care plan for Resident #1's and #8's fall risk, by failing to have fall mats in place next to bed while residents were lying down in bed. This deficient practice could place residents in the facility at risk of not receiving the necessary care or services as indicated in their comprehensive person-centered plans developed to address their needs. Findings include: Resident #1: Record review of Resident #1's Admission Record, dated 01/14/2025, reflected [AGE] year-old female admitted on [DATE]. Record review of Resident # 1's History and Physical dated 10/13/2024, revealed diagnoses of anxiety (feeling of worry, nervousness, or unease, typically about an imminent event or something with an uncertain outcome), dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), muscle weakness, and dizziness and giddiness (feeling lightheaded, unsteady, or off-balance). Record review of Resident # 1's MDS dated [DATE], revealed a BIMS score of 00 indicating the resident was severely impaired cognitively. Section G - Functional Status revealed Resident #1 required extensive assistance with bed mobility and transfers. Section J - Health Conditions revealed the resident had not had any falls since admission to the facility. Record review of Resident #1's Order Summary Report dated 01/14/2025, revealed an order with start time of 10/29/2024 for fall mats while in bed every shift. Record review of Resident #1's comprehensive care plan dated 01/14/2025, revealed Resident #1 was at risk for falls related to self-transferring without asking for assistance. Part of the interventions included Fall mats while in bed. Record review of Resident #1's Fall Risk assessment dated [DATE], revealed Resident #1 was a high risk for falls. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's event notes - fall, dated 12/28/2024, revealed Resident #1 was noted on the bed with her lower body hanging off the bed, called for help and was assisted to sit down on the floor. Resident #1 said I wanted to get in bed but my legs gave out. Resident #1 did not sustain any injuries. During an observation on 01/15/2025 at 9:25 a.m., revealed Resident #1 was lying in bed asleep. There were no fall mats positioned next to the bed. The fall mat was noted to be folded up and leaning against a dresser in the room. During observation and interview on 01/15/2025 at 9:55 a.m., revealed the DON observed Resident #1 did not have a fall mat in place. The DON said Resident #1 had a history of self-transferring and had been getting physically stronger. The DON said there should have been a fall mat in place. The DON said it was the responsibility of staff in the hall to ensure the fall mat was in place. During an interview on 01/15/2025 at 10:36 a.m., CNA F said Resident #1 was in bed and stayed in bed throughout the morning. CNA F said Resident #1 ate breakfast in her room. CNA F said Resident #1 was walking more and had not had any recent falls. CNA F said he must have forgotten to put the floor mat down after Resident #1 ate breakfast. Resident #8: Record review of Resident #8's Admission Record, dated 01/21/2025, reflected [AGE] year-old female with original admitted [DATE] and readmitted [DATE]. Resident #8's diagnoses included difficulty in walking and unsteadiness on feet. Record review of Resident # 8's MDS dated [DATE], revealed a BIMS score of 09 indicating the resident with moderate cognitive impairment. Section GG - Functional Abilities revealed Resident #8 had impairment to one side of her upper and lower extremities. Resident #8 required substantial/maximal assistance with lying to sitting on side of bed and was dependent for transfers. Section J - Health Conditions revealed Resident #8 had not had any falls since admission. Record review of Resident #8's Order Summary Report dated 01/23/2025, revealed an order with start time of 09/02/2024 for fall mats while in bed every shift. Record review of Resident #8's comprehensive care plan dated 01/23/2025, revealed Resident #8 was at risk for falls. Part of the interventions included Fall mats while in bed. Record review of Resident #8's Fall Risk assessment dated [DATE], revealed Resident #8 was at risk for falls. Record review of facility incidents from 10/01/2024 to 01/23/2025, revealed Resident #8 had not had any falls. During an observation on 01/23/2025 at 8:46 a.m., revealed Resident #8 was lying in bed asleep. There were no fall mats positioned next to the bed. Fall mat was noted folded up and leaning against a dresser and a wall in the room. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 01/23/2025 at 8:49 a.m., revealed the DON entered Resident #8's bedroom and said Resident #8 was a fall risk and should have floor mats in place. The DON said it was the CNAs responsibility to ensure mats were in place. The DON said she had placed the floor mats on the task assignment so that CNAs made sure to follow the care plan. The DON said Resident #8 had not had any falls in over four months. During an interview on 01/23/2025 at 9:05 a.m., LVN J said Resident #8 did not try to get out of bed during her shift. LVN J said Resident #8 was a fall risk. LVN J said fall mats were supposed to be on the sides of the bed while resident is in bed. LVN J said she did not know why the fall mats were not in place. LVN J said she had checked on Resident #8 around 8:00 a.m., when staff reported a concern with the resident coughing while she was drinking coffee. LVN J said she then left the room and the CNA remained in the room. LVN J said CNAs usually made sure the fall mats are in place. During an interview on 01/23/2025 at 9:11 a.m., CNA K said Resident #8 was a fall risk and fall mats were placed next to the bed whenever resident is in bed. CNA K said around 8:00 a.m. the resident coughed while drinking coffee and she called the nurse to check on her. CNA K said after the nurse checked on Resident #8, she must have forgotten to put down the fall mats back in place. CNA K said she knows the fall mats were part of Resident #8's care plan. Review of the facility-provided Comprehensive Care Planning policy, undated, revealed d in part Each resident will have a person-centered comprehensive care plan developed and implemented to meet his/her preferences and goals, and address the resident's medical, physical, mental, and psychosocial needs. The comprehensive care plan will reflect interventions to enable each resident to meet his/her objectives. Interventions are the specific care and services that will be implemented.