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	09/09/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for 4 (Resident #1, Resident #8, Resident #9, Resident #15) of 6 residents reviewed for dignity with meal assistance. The facility failed to ensure that Residents #1 was assisted with eating while staff were seated at eye level.The facility failed to ensure that Residents #8 was assisted with eating while staff were seated at eye level.The facility failed to ensure that Residents #15 was assisted with eating while staff were seated at eye level.The facility failed to ensure staff asked Resident #9 if the resident wanted to wear a clothing protector. This failure could place residents at risk of inadequate monitoring during feeding, which could result in, reduce dignity, and hinder the ability to respond promptly to signs of distress.Findings included:Resident #1Record review of Resident #1's face sheet undated , revealed, admission on [DATE] to the facility. Record review of Resident #1's facility history and physical, dated 10/10/24, revealed an [AGE] year old female diagnosed with pre-diabetes (Blood sugar is higher than normal, but not high enough to be called diabetes), dementia (A condition that affects the brain, making it hard to remember things, think clearly, or make everyday decisions), abnormal weight loss (Losing weight without trying, or losing more weight than what would be expected.), and cognitive communication deficit (Trouble thinking clearly and using words, which makes it harder to talk, understand others, or express needs.) Record review of Resident #1's annual MDS, dated [DATE], revealed a BIMS score of 4, indicating severely impaired cognition to be able to recall or make daily decisions. Resident #1's ADLs for eating was set up or clean up (nursing staff sets up or cleans up) assistance. Record review of Resident #1's care plan, dated 10/10/24, revealed ADLs for eating was supervision as needed. Observation on 09/08/25 at 12:19 PM, with Resident #1 and Student CNA, revealed, in Resident #1's room was Student CNA who was standing up with Resident #1's bed raised up. Student CNA was observed assisting with feeding Resident #1. On 09/08/25 at 2:06 PM, an attempt was made to interview Resident #1 but was asleep in her bed. Resident #8Record review of Resident #8's face sheet undated , revealed, admission on [DATE] and re-admission on [DATE] to the facility. Record review of Resident #8's quarterly MDS, dated [DATE], revealed a BIMS score of 5, indicating severely impaired cognition to be able to recall or make daily decisions. Resident #8's ADLs for eating was substantial/maximal (nursing staff more than half the effort) assistance. Record review of Resident #8's care plan, dated 09/17/24, revealed ADLs for eating as set up assistance. Observation on 09/08/25 at 12:22 PM, with Resident #8 and CNA S, revealed, in Resident #8's room CNA S was standing up while providing assistance with feeding Resident #8. Resident #8's bed was in the mid-low position around CNA S's waist area. CNA S was hunched over while trying to assist Resident #8 with feeding. On 09/09/25 multiple attempts were made to interview Resident #8 but were unsuccessful. During an interview on 09/09/25 at 10:09 AM, with Student CNA, she stated she had received training on assisting residents with feeding. Student CNA stated when giving food to the resident the assisting staff had to be sitting down. Student CNA stated she did not remember why they had to be sitting down when assisting a resident with feeding. Student CNA stated standing up might make the resident rush to eat. Resident #15Record review of Resident #15's face sheet undated, revealed admission on [DATE] to the facility. Record review of Resident #15's facility history and physical, dated 06/22/25, revealed an [AGE] year-old female diagnosed diabetes mellitus (condition where the body has trouble using sugar properly, leading to high blood sugar levels that need to be managed with diet, medicine, or insulin), dementia (brain condition that causes memory problems, confusion, and difficulty making decisions or doing everyday tasks), and impaired mobility (trouble moving around, such as walking, standing, or getting from place to place without help). Record review of Resident #15's quarterly MDS, dated [DATE], revealed a moderately impaired cognition BIMS score of 8 to be able to recall or make daily decisions. Resident #15's functional abilities for eating, revealed, partial/moderate (nursing staff does less than half the effort) assistance. Record review of Resident #15's care plan, dated 03/01/24, revealed, ADL care of eating was supervision as needed. Encourage the resident to participate to the fullest extent possible with each interaction. Observation on 09/08/25 at 12:29 PM, with Resident #15 and CNA O, revealed in Resident #15's room was CNA O who was standing up while assisting with feeding Resident #15. On 09/09/25 multiple attempts were made to interview Resident #15 but was unsuccessful. During an interview on 09/08/25 at 3:05 PM, the Dietary

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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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 - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable disease and infection for 1 of 2 residents (Resident #12) reviewed for infection control in that: The facility failed to ensure staff followed infection control practices during wound care when Wound Care Nurse did not change gloves between contaminated and clean tasks for Resident #12. This facility failure could place residents at risk for worsening pressure injuries, pain, and a decline in health. Findings include:Record review of Resident #12's face sheet undated, revealed admission on [DATE] and re-admission on [DATE] to the facility. Record review of Resident #12's history and physical dated 7/28/25 revealed diagnoses of unspecified dementia (cases where the specific type of dementia cannot be clearly identified despite the presence of cognitive decline and memory loss), and end stage renal disease (your kidneys no longer work as they should to meet your body's needs). Record review of Resident #12's admission MDS, dated [DATE], revealed a severe cognitive impairment BIMS score of 6 to be able to recall or make daily decisions. Resident #12 was coded substantial/Maximum (nursing staff does more than half the effort) assistance with roll left or right, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed to chair transfer. Resident #12 was at risk for pressure ulcers/injuries and was coded for pressure reducing device for bed. Record review of Resident #12's physician order, dated 9/2/25, revealed cleanse sacral PI with normal saline/wound cleanser pat dry apply Anasept, collagen secure with optifoam absorbent dressing/ change daily until resolved, one time a day for stage 2.Record review of Resident #12's care plan, dated 9/1/25, revealed a focus area for stage 2 pressure injury to sacrum with interventions that included administrator treatments are ordered and monitor for effectiveness; assess/ record/ monitor wound healing at least weekly/ report declines to the MD.During an observation and interview on 09/08/25 at 2:20 pm, the Wound Care Nurse donned(put on) gloves and assisted CNA W with repositioning Resident #12 by pulling on the sheets. The Wound Care Nurse then pulled down Resident #12's pants and briefs, removed the dressing on the sacrum, cleansed and dried the wound, applied Anasept (used to treat or prevent infections caused by cuts or abrasions, skin ulcers, pressure ulcers, diabetic foot ulcers, or surgery), handled collagen (collagen supplements or therapies to enhance the body's collagen production or to address issues related to aging or skin health) (cutting it with the same gloves), and applied adhesive gauze. The Wound Care Nurse stated her right hand was her clean hand and her left hand was her dirty hand, but acknowledged she should have changed gloves prior to touching clean supplies. She voiced being nervous but stated this was not an excuse. Resident #12 was not able to answer questions. During an interview on 09/09/25 at 10:50 AM, the DON stated when wound care was conducted it was expected for the Wound Care Nurse to change out her gloves between clean and dirty dressings. The DON stated gloves should be changed after re-positioning. The DON stated she had not trained the Wound Care Nurse regarding cross contamination during wound care. The DON stated the risk of not changing out her gloves was introducing infection due to the dirty gloves.During an interview on 09/09/25 at 11:28 AM, the Administrator, stated he was aware of the concern with the way the wound care was conducted. The Administrator stated it was expected for the Wound Care Nurse to follow facility policy and should have known to change out her gloves when preforming wound care. The Administrator stated it would be a risk of cross contamination. Record review of the facility Pressure Injury: Prevention, Assessment and Treatment Policy dated 05/-5/25, revealed, Procedure: Nursing personnel will continually aim to maintain the skin integrity, tone, turgor, and circulation to prevent breakdown, injury, and infection.Record review of the facility Treatment Table Policy dated 2003, revealed, 1. Wash hands. Put on gloves. 2. Place wax paper on wound care bedside table or small cart. 3. Gather treatment supplies. Open up and place on top of wax paper. One end will be considered clean, and the other end of table will be open for dirty. 4. Place wax paper over top of supplies. 5. On open end place linens, saline, red bag, scissors, pen, camera, etc. on top of second cover of wax paper. 6. Lock up treatment cart and proceed to resident's room. Refer to treatment protocol for treatment procedure and application. 7. After treatment place dirty linens, red bags, scissors, pen, etc. to be cleaned on open end.