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	01/22/2026

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 - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure that the residents had the right to a dignified existence for 2 (Resident #5 & Resident #6) of 4 residents reviewed for resident rights. The facility failed to ensure the urinary collection bags for Resident #5 and Resident #6's catheters were covered with a privacy bag. This failure could place residents at risk for a loss of dignity, decreased self-worth and decreased self-esteem.Resident #5: Record review of Resident #5's face sheet dated 01/22/2026, revealed an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #5's diagnoses included disorder of urinary system (conditions affecting the structures near the urinary tract), Chronic viral Hepatitis C (affects the liver), Hypokalemia (low potassium in blood serum), Acute kidney disease (kidneys stop working), cirrhosis of the liver (liver damage). Record review of Resident #5's MDS dated [DATE], reflected a BIMS score of 00, which indicated severe cognitive impairment. Resident #5 had no impairment to of upper extremity, and no impairment to lower extremities. Resident #5 had an indwelling catheter (including suprapubic catheter and nephrostomy tube, which is a thin catheter that drains pee from the kidneys into a bag).). Record review of Resident #5's Order Summary Report dated 01/22/2026, stated Essure foley bag is in bag is in privacy bag while in bed or w/c. Record review of Resident #5's Care Plan dated 01/22/2026, stated focus Resident #5 has (indwelling Suprapubic Catheter) The goal stated, The resident will show no s/sx of urinary infection through review date, Interventions/task stated Catheter: The resident has a size type of catheter position catheter bag and tubing below the level of the bladder and in a privacy bag. In an interview and observation on 01/22/2026 at 09:07 a.m., revealed Resident #5 was lying in bed and family member was present in the room with her. Family members stated they had only been at the facility for a short period of time but so far loved it. During interview with family member Resident #5's Catheter bag was without a privacy bag. In an interview on 01/22/2026 at 09:13 a.m., Nurse M stated the Foley should always have a privacy bag on them. Nurse M stated staff as well as himself were trained upon hire and annually or more to always have a privacy bag for the respect of the residents and others. Resident #6: Record review of Resident #6's face sheet dated 01/22/2026, revealed a [AGE] year-old female who was admitted to the facility on [DATE], with a readmission date of 12/16/2025. Resident #6's diagnoses dysphagia (difficulty Swallowing), muscle wasting and atrophy (loss of muscle mass and strength), anemia (not enough heathy red blood cells), hyperlipidemia (High Cholesterol), Dementia (memory loss), Hypertension (High blood pressure), GERD, neuromuscular dysfunction of bladder (electrical signals between the nervous system and bladder function). Record review of Resident #6's MDS dated [DATE], reflected a BIMS score of 00, which indicated severe cognitive impairment. Resident #6 had impairment on one side of upper extremity, and impairment on both sides of lower extremities. Resident #6 had an indwelling catheter (including suprapubic catheter and nephrostomy tube, which is a thin catheter that drains pee from the kidneys into a bag). (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #6's Order Summary Report dated 01/22/2026, stated Foley catheter care every shift, (Ensure the foley is secured on the thigh and drainage bag is inside a privacy bag attached to bed rail) Every shift. Record review of Resident #6's Care Plan dated 12/15/2025, focus stated Resident #6 has indwelling catheter dx neuromuscular dysfunction of bladder. The goal stated, Resident #6 will be/remain free from catheter related trauma through review date. With interventions stating, Position catheter bag and tubing below the level of the bladder and in a privacy bag. In an observation and interview on 01/22/2026 at 10:55 a.m., revealed Resident #6 was lying asleep in bed. Resident #6 did not acknowledge the Investigator. The catheter bag was clipped on to the right side of the bed which was viewable from the hallway with no privacy bag covering it. Resident #6 was not alert or oriented and was non interviewable. In an interview on 01/22/2026 at 10:30 a.m., CNA P stated they had been emloyed with the facility for 13 years and stated that staff were always trained on infection prevention and on privacy for residents. CNA P stated catheter bags should always have privacy bags on them, if its not reisdents could be embarresed which is adignity issue. In an interview on 01/22/2026 at 10:32 a.m., LVN D stated catheter bags should always have a privacy bag on them. LVN D stated she was provided resident rights training a couple of months back but couldn't recall exatly when. In an interview on 01/22/2026 at 12:34 p.m., CNA A stated that privacy bags should always be on the catheter bags. The risk was a privacy issue. CNA A stated he was trained on resident rights. In an interview on 01/22/2026 at 12:48 p.m., the RN stated cateter bags should be placed in a privacy bag and should not be lying on the floor. The RN explained that catheter bags were to be secured on the bed frame using the designated tie, hung on the left side of the bed frame, and always placed in a privacy bag to maintain resident dignity, as residents may not want the catheter bag visible. The RN further stated that if a catheter bag did not have a privacy bag, staff, including RNs and CNAs, were expected to report the issue to a supervisor or charge nurse and place the catheter bag in a privacy bag to protect resident privacy and HIPPA requirements. In an interview on 01/22/2026 at 01:42 p.m., the DON stated catheter bags were to be placed below the bladder at the end of the bed and in a privacy bag. The responsibility falls on all staff but more nursing to ensure that procedure is being followed. The risk of a catheter bag not having a blue privacy bag was dignity issue. The DON stated staff had been trained upon hire and during any in-services when needed. In an interview on 01/22/2026 at 03:42 p.m., the Administrator stated that staff were to care for the catheter bags, and they must always be covered. The risk of catheter bags not having any privacy bags on them was a dignity issue. The Administrator stated he performed rounds around the facility and was not aware of anyone having issues with their Foley catheter. He stated that during morning huddle he concentrated to make sure Foley catheter care was getting done correctly and no issues have been brought up regarding Foley catheters. Review of facility policy titled Resident Rights policy, date not provided, reveled, A facility must 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. The facility must protect and promote the rights for the residents. The resident has a right to be treated with respect and dignity, including privacy and confidentiality.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infection for 3 of 4 residents (Resident #5, Resident #7, Resident #8) reviewed for infection control. The facility failed to ensure the urinary catheter bag for Resident #5, Resident #7, and Resident #8 were anchored and secured to prevent infection. This failure could place residents at risk of infection due to improper care practices.Resident #5: Record review of Resident #5's face sheet dated 01/22/2026, revealed an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #5's diagnoses included disorder of urinary system, Chronic viral Hepatitis C, Hypokalemia (Low Potassium in blood Serum) Acute kidney disease (kidneys stop working), cirrhosis of the liver. Record review of Resident #5's MDS dated [DATE], reflected a BIMS score of 00, which indicated severe cognitive impairment. Resident #5 had no impairment to of upper extremity, and no impairment to lower extremities. Resident #5 had an indwelling catheter (including suprapubic catheter and nephrostomy tube which is a thin catheter that drains pee from the kidneys into a bag). Record review of Resident #5's Order Summary Report dated 01/22/2026, stated Ensure foley bag is in bag is in privacy bag while in bed or w/c. Record review of Resident #5's Care Plan dated 01/22/2026, revealed, focus [Resident #5] has (indwelling Suprapubic Catheter) The goal revealed, The resident will show no s/sx of urinary infection through review date, Interventions/task stated Catheter: The resident has a size type of catheter position catheter bag and tubing below the level of the bladder and in a privacy bag, Check tubing for kinks and maintain the drainage bag off the floor In an interview and observation on 01/22/2026 at 09:07 a.m., revealed Resident #5 was lying in bed and a family member was present in the room with her. The family members stated they had only been at the facility for a short period of time but so far loved it. During the interview with the family member Resident #5's catheter bag was lying on the floor. Resident #7: Record review of Resident #7's face sheet dated 01/22/2026, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #7's diagnoses included type 2 diabetes, Thrombocytopenia (Abnormally low platelet count), Benign prostatic hyperplasia with lower urinary tract symptoms (enlarged prostate, growth prostate gland). Record review of Resident #7's MDS dated [DATE], reflected a BIMS score of 08, which indicated moderate cognitive impairment. Resident #7 had impairment on one side of upper extremity, and impairment on both sides of lower extremities. Resident #7 had an indwelling catheter (including suprapubic catheter and nephrostomy tube, which is a thin catheter that drains pee from the kidneys into a bag).). Record review of Resident #7's Order Summary Report dated 01/22/2026, stated Ensure foley bag is in privacy bag while in bed or w/c every shift for foley catheter. Record review of Resident #7's hospital history and physical dated 09/02/2025 revealed an [AGE] year-old male with PMH of Cholangitis with Biliary stent Removal (Bile Duct diseases due to stent removal), Cholelithiasis (Gallstones are hardened pieces of bile), Thrombocytopenia (Low Blood Platelet count), Hyperammonemia (elevated levels of ammonia in the blood), Acute Hypoxic Respiratory Failure (a life threatening condition characterized by insufficient oxygen in the blood). Record review of Resident #7's Care Plan dated 01/22/2026, revealed, focus The resident has indwelling catheter with a goal, The resident will show no s/sx of urinary infection through review date intervention/tasks position catheter bag and tubing below the level of the bladder and in a privacy bag, check tubing for kinks and maintain the drainage bag off the floor. In an observation on 01/21/2026 at 10:35 AM Resident #7 was observed lying asleep in bed. Resident #7 did not respond or acknowledge greeting. Catheter bag was located on the right side of the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bed inside the blue privacy bag. Catheter bag was not hooked to the bedrail and was lying sideways with tubing on the floor. Resident # 8: Record review of Resident #8's face sheet dated 01/22/2026, revealed a [AGE] year-old male who was admitted to the facility on [DATE], with a readmission on [DATE]. Resident #8's diagnoses included encounter for surgical aftercare following surgery on the digestive system, chronic kidney disease, conversion disorder with seizures, viral hepatitis C, Dementia. Type 2 diabetes, UTI. Record review of Resident #8's MDS dated [DATE], reflected a BIMS score of 00, which indicated severe cognitive impairment. Resident #8 had impairment on one side of upper extremity, and impairment on both sides of lower extremities. Resident #8 had an indwelling catheter (including suprapubic catheter and nephrostomy tube, which is a thin catheter that drains pee from the kidneys into a bag).). Record review of Resident #8's Order Summary Report dated 01/22/2026, revealed Ensure foley bag is in privacy bag while in bed or w/c every shift for foley catheter every shift. Record review of Resident #8's Care Plan dated 01/22/2026, revealed focus, The resident has indwelling catheter obstructive uropathy with a goal [Resident #8] will be/remain free from catheter related trauma interventions Position bag and tubing below the level of the bladder and in a privacy bag, check tubing for kinks and maintain the drainage bag off the floor. In an observation on 01/21/2026 at 10:35 AM Resident #8 was observed lying asleep in bed. Resident #8 became aggressive when the Investigator attempted conversation. The catheter bag was located on the right side of the bed, inside the blue privacy bag. The catheter bag was not hooked to bedrail and was sitting upright on a fall mat. In an interview on 01/21/2026 at 10:45 am, LVN N stated that the cather bags could not be placed any other way as the beds have to be at the lowest position so the bag will always be touching the floor or the fall mats. LVN N was able to fix Resident #7 and Residnet #8's Foley catheter bag to where the bag was not touching the floor mat anymore, and was able to sit the bag upright to prevent leakage. LVN N stated they took training on privacy bags and infection control but since they were lying on the floor mat it should be okay. In an interview on 01/22/2026 at 10:30 a.m., CNA P stated they had been emloyed with the facility for 13 years and stated that staff were always trained on infection prevention and on privacy for residents. CNA P stated that if there were Foley bags on the floor that was infection control and catheter bags should always have privacy bags on them; if not then reisdents could be embarresed which was adignity issue. In an interview on 01/22/2026 at 10:32 a.m., LVN D stated that if a catheter bag was on the floor that it would be infection control. LVN D stated she was provided infection control and resident rights training a couple of months back but couldn't recall exatly when. In an interview on 01/22/2026 at 12:34 p.m., CNA A stated the catheter bags should not be on the floor. The risks were infection control. CNA A stated he was trained on both infection control prevention and resident rights. In an interview on 01/22/2026 at 12:48 p.m., RN stated that placing a catheter bag on the floor was an infection control concern, as catheter bags were not to touch any surfaces. Additionally, the RN stated that a catheter bag placed on the floor could be stepped on or could leak. In an interview on 01/22/2026 at 01:42 p.m., the DON stated catheter bags were to be placed below the bladder at the end of the bed and up off the floor and in a privacy bag. The responsibility fell on all staff but more nursing to ensure that procedure was being followed. For fall risk residents it was hard to keep the privacy bag off the floor because the bed must be at the lowest position but the Foley bag still needed to be hooked in place on the bedrail as well as placing the privacy bag with the catheter bag into a basin, so the bag was not touching the floor. The DON stated she had just become aware of placing the bags into a basin today and was unaware of that procedure. The DON informed that she would get in-services started right away so that staff knew to place catheter bags inside a basin for fall risk residents. The risk of a catheter bag (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not having a blue privacy bag was dignity issue, and the risk of bags being on the floor was infection control. Staff had been trained upon hire and during any in0services when needed. The DON stated, There is no policy in regard to placing the catheter bag inside a basin, it is just a requirement for this facility and others associated to the same company. In an interview on 01/22/2026 at 03:42 p.m., the Administrator stated that staff were to care for the catheter bags, and they must always be covered. The risk of them being on the floor would be infection control and bags not having any privacy bags on them were a dignity issue. The Administrator stated he performed rounds around the facility and was not aware of anyone having issues with their Foley catheters. He stated that during morning huddle he concentrated to make sure Foley catheter care was getting done correctly and no issues had been brought up regarding Foley catheters. Record review of facility policy titled Catheter Care, no date provided, revealed, Keep tubing off floor and minimize friction or movement at insertion site, be sure the catheter tubing and drainage bag are kept off the floor. Record review of facility policy titled Standard Precautions, no date provided, revealed, implementations of standard precautions constitute the primary strategy for preventing healthcare associated transmission of infectious agents among residents and healthcare personnel. Appropriate infection control measures should be used in each resident interaction. Contaminated: The presence of reasonably anticipated presence of blood or other potentially infectious materials on an items or surface.