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	04/23/2026

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the resident had a right to be treated with respect and dignity including the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms for 1 of 5 residents (Resident #3) reviewed for restraints. The facility failed to ensure Resident #3 was free from any physical restraint when a pillow was observed tucked under the bedsheet in a manner that restricted movement to Resident #3. This failure could place residents at risk for restricted movement, feeling of entrapment, decreased mobility, and possible injury.Record review of Resident #3's face sheet, dated 04/22/2026, reflected an [AGE] year-old female who was admitted to the facility on [DATE] and then readmitted on [DATE]. Resident #13 had diagnoses which included Unspecified Dementia (decline in mental abilities), Amnesia (total loss of memory), Ataxia (lack of muscle control or coordination), communication deficit (difficulty understanding of using spoken/written language), pain in joints (discomfort, stiffness, or soreness in the bones), displaced fracture of base of third metacarpal bone (long bone in your palm connecting your right middle finger to your wrist is broken near the wrist, and the pieces have moved out of their normal alignment, right hand (long bone in your palm connecting your right middle finger to your wrist is broken near the wrist, and the pieces have moved out of their normal alignment), rectal prolapse (last part of the intestines (rectum) loses its support, slides out of place, and protrudes through the anus), dysphagia (difficulty swallowing), depressive disorder (intense feeling of sadness, emptiness, or loss of interest in activities), gait and mobility (breakdown of gait and mobility), osteoarthritis (arthritis in the bones), muscle wasting and weakness (muscles shrink and lose power making daily tasks difficult), Hypothyroidism (thyroid gland in the neck does not produce enough thyroid hormones, causing the body's metabolism to slow down), type 2 diabetes (he body cannot properly use or make enough insulin to manage blood sugar), hyperglyceridemia (too much of a specific type of fat triglycerides circulating in your blood), polyneuropathy (multiple peripheral nerves throughout the body are damaged). Record review of Resident #3's Quarterly MDS, dated [DATE], reflected a BIMS score of 01, which indicated the resident had severe cognitive impairment. The resident had impairment on one side in upper extremity (shoulder, elbow, wrist, hand) and had impairment on both sides of lower extremities (hip, knee, ankle, foot). Record review of Resident #3's Care Plan, dated 04/22/2026, reflected no focus, goal or interventions that would indicate a medical use of a pillow tucked under the bed sheet. Record Review of Resident #3's Orders dated, 04/22/2026, did not reveal any physical orders that would indicate a medical use of a pillow tucked under the bed sheet. In an interview and observation on 04/22/2026 at 11:43 AM, revealed Resident #3 was lying in bed asleep tilted on her left side. The Hospice nurse was sitting on a chair and stated she had just completed her nursing assessment on the resident. During observation, the hospice nurse removed the blanket that was covering the resident to show the resident had no bruising or swelling on any part of her body and a pillow was tucked under the resident's bed sheet. The Hospice nurse stated the pillow placement was already there when she arrived and did not see who had placed it. Hospice nurse stated she had no (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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	idea why the pillow was placed there or what the use for it was. In an observation and interview on 04/22/2026 at 11:59 AM, revealed the resident was awake and sitting at a 90 degree angle and food tray front of her. Upon observation of resident's room, and the pillow placement under the bedsheets were no longer there. LVN S was shown a picture of the pillow under the bed sheet and was asked what the risks were of having a pillow under the bedsheet. LVN S stated it was not appropriate and it should not have been there. It causes a restraint to the resident. In an interview on 04/22/2026 at 03:38 PM, with Resident #3 responsible party (RP) stated that be believed the pillow had been placed to keep Resident #3 positioned on her side to prevent wounds. The RP stated that Resident #3 was unable to move independently, very fragile, and was bedbound. In in interview on 04/23/2026 at 05:13 PM, with DON was shown a photograph of a pillow tucked under the bedsheet of Resident #3. DON stated that the use of the pillow in this matter was considered a restraint and that staff were not trained to perform this practice. The DON explained that the risk to the resident included the possibility of feeling trapped and being unable to move, especially since the resident did not ambulate. DON stated that the responsibility for monitoring this practice fell on the charge nurses. The DON stated reported that residents were expected to be responded at least every two hours. In an interview on 04/23/26 at 06:06 PM, with the Administrator, the Administrator was also shown the photograph of the pillow tucked into the sheet. Administrator stated that the pillow had been keeping the resident in bed and confirmed that this would be considered a restraint. Administrator stated that staff were not trained to use pillows in this way and stated she had not previously observed or instructed staff to do so. She stated that only approved devices, such as U-bars, were permitted. Administrator stated that staff received training on restraints during orientation upon hire and that nursing staff were responsible for ensuring residents were not improperly restrained. The administrator stated that residents had the right to move freely in and out of bed. Record review of the facilities policy named Restraints reflected It is the policy of this facility to maintain an environment that prohibits the use of restraints or discipline or convenience restraint usage shall be limited to circumstances in which the resident has medical symptoms that warrant the use of restraint A restraint assessment committee will evaluate and establish the need for restraint youth or restraint reduction for residents in our facility the facility is committed to nurturing the autonomy and independence of our residents by attempting to provide a restraint free environment. Physical restraint Any manual method or physical mechanical device material or equipment attached or adjacent to the residence body that the resident cannot remove easily which restricts freedom or movement or normal access to 1 body physical restraints include but are not limited to leg restraints arm restraints handmaidens soft tie or vest weird true safety bars [NAME] chairs lap cushions and trades that the resident cannot remove. 5.) Those three staff will develop a care plan for the alternative method identified and or the restraint usage. 18) Practices that are not to be used: using bedrooms to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility while in bed sucking sheets so tightly that a bed bound resident cannot move using wheelchair safety bar to prevent a resident from rising out of the chair placing a resident in a chair that prevents the resident from rising and placing a resident who uses a wheelchair so close to the wall that the law prevents the resident from rising.