

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675479	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2024
NAME OF PROVIDER OR SUPPLIER Franklin Heights Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 223 S Resler El Paso, TX 79912	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46998</p> <p>Based on interview and record review the facility failed to ensure alleged violations involving neglect or mistreatment, including misappropriation were reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 2 (Resident #2 and Resident #6) of 4 residents reviewed for reporting.</p> <p>Resident #2 reported to facility staff missing \$400 from his wallet and the facility failed to report the incident to the state agency.</p> <p>LVN B reported to the Administrator that LVN A was neglecting Resident #6 by not conducting wound care as per physician ordered.</p> <p>This failure could place all residents at risk for misappropriation and neglect by not immediately reporting allegations of misappropriation to the proper authorities at the facility, other officials, and state survey agency.</p> <p>Findings included:</p> <p>Resident #2</p> <p>Record review of Resident #2's face sheet dated 03/18/24, revealed, admission on 02/21/24 to the facility.</p> <p>Record review of Resident #2's facility history and physical dated 02/21/24, revealed, a [AGE] year-old male diagnosed with hypertension (when the pressure in your blood vessels is too high (140/90 mmHg or higher)), dyslipidemia (the imbalance of lipids), and morbid obesity (being severely overweight).</p> <p>(continued on next page)</p>

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #2's admission MDS dated [DATE], revealed, a moderate cognition to be able to recall and make daily decisions BIMS (evaluates cognitive impairment and can help with dementia diagnosis) score of 13. Active diagnoses did not reveal any neurological diagnoses that Resident #2 might have been affected by.</p> <p>Record review of Resident #2's progress notes generated by LVN A dated 03/08/24 at 2:23 AM, revealed, Resident #2 reporting he was missing money from his wallet. LVN A spoke with Resident #2. Resident #2 first stated, I am missing money I had \$400. Resident #2 proceeded to count money with LVN A and CNA B present. Resident #2 counted \$480. Resident #2 then stated, Oh I had \$400 just in hundred bills. Money was recounted by LVN A in front of resident with CNA B present. Resident #2 stated, I don't know how I lost the money. I always keep my wallet in my chest within sight. Resident #2 has wallet with credit cards and total \$480 cash.</p> <p>Record review of Resident #2's progress notes generated by Social Worker dated 03/08/24 at 10:43 AM, revealed, Resident #2 was interviewed at bedside regarding the allegation of lost money. Resident #2 reported he admitted the facility with \$900. Resident #2 stated since he had been at the facility he only gave \$40 to a friend for his birthday. When asked where Resident #2 keeps his wallet. Resident #2 stated he holds it under his shirt on his chest and that the wallet has not left his possession. Resident #2 was offered to have Administration keep his wallet in a safe. Resident refused for Social Worker to take wallet to safe and asked for Administrator. Administrator notified and Resident #2 refused to allow Social Worker to count the cash, or he did not want to get the police involved. No further concerns reported.</p> <p>Record review of Resident #2's progress notes generated by Social Worker dated 03/08/24 at 4:51 PM, revealed, called non-emergency - Number to complete a report regarding the allegation of lost money. Operator stated an officer would visit Resident #2, when they get freed up. Operator advised Social Worker to be patient as officers are busy. Social Worker continued to monitor.</p> <p>Record review of the facility Resident Grievance for Resident #2 dated 03/08/24, revealed, it was reported to the Administrator related to the missing \$400. Social Worker was assigned to investigate the grievance. Corrective action was reported to local police. Resident #2 gave his wallet to his family member. Grievance was not resolved, and money not found.</p> <p>During an interview on 03/19/24 at 3:03 PM, with the Administrator, she stated she received a report from Resident #2 that he was missing \$400 from his wallet. The Administrator stated the Regional Nurse, her, and the Area Director of Operations conducted the investigation. The Administrator stated the Social Worker also talked to Resident #2 and called the local police. The Administrator stated Resident #2 did not want to do a report and said it was not important. The Administrator stated she spoke with LVN A on 03/08/24, who Resident #2 had initially reported it too. The Administrator stated that Resident #2 had told LVN A that no one had taken his money and he slept with his wallet. The Administrator stated LVN A had counted the money from the wallet in front of Resident #2 and counted \$480. The Administrator stated that Resident #2 had said he was originally missing \$800 and \$400 were taken from it. The Administrator stated it was not reported to state because Resident #2's stories were inconsistent.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 03/19/24 at 5:09 PM, with the DON, she stated she did not speak to Resident #2 in regard to the missing \$400s. The DON stated the alleged allegation from Resident #2 was not reported to state agency. The DON stated from what she heard Resident #2's story was very inconsistent. The DON stated Resident #2 had stated he was missing \$400s and then turned around and told the Social Worker that he had \$800s. The DON stated the facility, nor the family member could not confirm where Resident #2 had acquired the money. The DON stated Resident #2 was refusing to call the local police. The DON stated Resident #2 does not leave his wallet out of his sight. The DON stated that it did not require a state notification.</p> <p>During an interview on 03/19/24 at 10:01 AM, with the Social Worker, she stated she was notified about Resident #2 claiming he had \$400s missing. The Social Worker stated Resident #2 said he had \$850 and had \$400 was missing and only had \$450s in his wallet. The Social Worker stated she told him the facility could hold on to his wallet to keep it safe but he refused. The Social Worker stated it was reported to the local police over the phone. The Social Worker stated Resident #2's family member had gone into the facility to pick up his wallet. The Social Worker stated that she assumed Resident #2 had not told the facility he was carrying that much money. The Social Worker stated she did not know what was done about replacing the missing money. The Social Worker stated she did not know if the facility had notified the state agency. The Social Worker stated she had been trained to do investigations and if found true then the Administrator was to report it to the state agency.</p> <p>During an interview on 03/20/24 at 9:33 AM, with Resident #2, he stated he was missing \$400s from his wallet. Resident #2 stated on 03/08/24 in the nighttime he had notified the night nurse LVN A about the missing money . Resident #2 stated they both counted the money and he had \$480s. Resident #2 stated originally, he had \$880s in his wallet and was missing \$400s and only had \$480 left. Resident #2 stated he called the local police with the Social Worker and was told that it was not an emergency and when the local police have time that they would go to the facility. Resident #2 stated he always has his money with him on his chest and would have felt it and did not know how the money went missing. Resident #2 stated his family member took his wallet for safe keeping.</p> <p>During an interview on 03/20/24 at 11:21 AM, with the Area Director of Operations, she stated the Administrator was providing her all the documentation on all investigations conducted. The Area Director of Operations stated Resident #2 never alleged that someone took his money. Area Director of Operations stated it was investigated by the Administrator and herself. The Area Director of Operations stated Resident #2 claimed he was missing \$400s which was reported at night and the night nurse counted the money revealing after counting the money to be \$490s. The Area Director of Operations stated then Resident #2 changed his story and stated he had \$800s. The Area Director of Operations stated then Resident #2 had said no one took the money because he sleeps with his wallet. The Area Director of Operations stated the local police was notified and they did go to the facility but Resident #2 did not want to talk to them. The Area Director of Operations stated she was not aware that the Social Worker and Resident #2 had made the phone call to the local police together. The Area Director of Operations stated it was not reported to state and should not be reported to state as per the facility policy and provider letter 19-17. The Area Director of Operations stated there was no misappropriation or exploitation identified during the investigation.</p> <p>During an interview on 03/20/24 at 11:46 AM, with LVN A, she stated Resident #2 notified her of missing \$400s on 03/08/24. LVN A stated she helped him count it and he had \$480s. LVN A stated at no point did Resident #2 say someone had taken his money. LVN A stated she reported to the ADON in the morning and in the 24-hour report.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #6</p> <p>Record review of Resident #6's face sheet dated 03/18/24, revealed, admission on 01/06/23 to the facility.</p> <p>Record review of Resident #6's facility history and physical (most current history and physical in facility system) dated 01/06/23, revealed, a [AGE] year-old female (present time Resident #6 was 52-years-old) diagnosed with Severe intellectual disability (major delays in development, and individuals often have the ability to understand speech but otherwise have limited communication skill), Cerebral palsy (a group of conditions that affect movement and posture), epilepsy (a disorder of the brain characterized by repeated seizures), and perturbation (anxiety or uneasiness).</p> <p>Record review of Resident #6's quarterly MDS dated [DATE], revealed, no cognitive BIMS (evaluates cognitive impairment and can help with dementia diagnosis) to be able to recall and make daily decisions was taken for whatever reason. Resident #6 was totally dependent on facility on all activities of daily living. Resident #6 was diagnosed with cerebral palsy, severe intellectual disabilities. Resident #6 was at risk of pressure ulcers.</p> <p>Record review of Resident #6's physician orders dated 03/12/24, revealed, left lateral malleolus pressure injury, cleanse with normal saline, pat dry, apply anasept ointment sheet and abdominal pad , cover with kerlex dressing and secure with tape every day and as needed and every shift.</p> <p>Record review of Resident #6's Weekly Skin Assessment revealed the following:</p> <p>*dated 02/22/24, Callus area to outer ankle. No signs or symptoms of infection or cracked skin. Protective dressing over affect area for added protection.</p> <p>*dated 02/29/24, To bilateral outer ankles Resident #6 has callus areas over ankle bone, cleansed and covered with foam dressing 2 times a week for protection.</p> <p>/dated 03/07/24, callus areas to bilateral ankles.</p> <p>Record review of Resident #6's care plan dated 05/16/23, revealed, has potential for pressure ulcer development related to limited physical mobility. Administer medications as ordered. Redness, blisters, bruises, discoloration noted during bath or daily care.</p> <p>Record review of LVN D text message sent to state surveyor dated 03/18/24, revealed, a text message dated 03/12/24, stated the following:</p> <p>LVN D stated, this didn't happen overnight. These are in house and per wound care orders these are callouses.</p> <p>Regional Nurse stated, oh my god!! Let me take care.</p> <p>LVN D stated, Wound care orders are 3 times a week, just a protective dressing. This should be a daily treatment. Resident #6 should be on caseload. Last skin assessment says calloused areas to bilateral ankles.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Regional Nurse stated, Ok I'm driving but will check. Thank you for sharing this with Administrator also LVN D but like I already told you I'll look at it as soon as possible.</p> <p>I reported it to the Administrator because this was neglect.</p> <p>Regional Nurse stated, Call me. Call me. Again (with an emoji face, the grimacing face (depicts awkwardness or nervousness)).</p> <p>Record review of Administrator text message sent to state surveyor dated 03/18/24, revealed, text message undated named LVN D from 2-10PM stated the following:</p> <p>At 7:49 PM - Photo of wound on unknown body part (unknown if left or right ankle).</p> <p>At 7:50 PM - LVN D stated these are in house pressure injuries per wound care orders these are callouses. This was ridiculous Administrator. It's straight up abuse.</p> <p>At 7:51 PM - Patient was Resident #6. These should be treated daily these are orders for 3 times a week. Any nurse would tell you that needs to be done daily.</p> <p>At 7:53 PM - I'm not clinical, I'm talking to nursing management now. What can you do for the patient right now? Let's ensure we do a pain assessment for the patient.</p> <p>During an attempted interview on 03/15/24 at 8:57 AM, with Resident #6, she when asked questions did not respond. Resident #6 was just smiling and said nothing. Interview was terminated as there was no response back.</p> <p>During an interview on 03/18/24 at 2:38 PM, with LVN D, he stated he was notified by CNA E that Resident #6 needed to have her patches replaced on her wound on her ankles. LVN D stated when he went to Resident #6's room and found blood on the sheets where Resident #6 had callous but were now full wounds. LVN D stated he had reported it to the Regional Nurse and the Administrator. LVN D stated he looked at Resident #6's assessment and only saw the callous and not the wounds. LVN D stated when LVN C was not at the facility, the nurse should be directed to provide wound care by the DON/ADON or passed on in report. LVN D stated in the morning LVN C had said it was a callous and, in the evening, it was already wounds. LVN D stated that LVN C was suspended for Resident #6 wounds to her ankles.</p> <p>During an interview on 03/18/24 at 4:17 PM, with the Administrator, she stated LVN C was suspended. The Administrator stated LVN D had notified her that Resident #6 had a pressure ulcer. The Administrator stated the Regional Nurse had suspended LVN C pending investigation of Resident #6 wounds. The Administrator stated the Regional Nurse went over Resident #6's charts and did not find anything wrong with the documentation, information, and charting of Resident #6. The Administrator stated LVN Cs clinical notes looked okay.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 03/19/24 at 1:56 PM, with the Regional Nurse, she stated she had received a text message from LVN D regarding Resident #6. Regional Nurse stated LVN C was treating callus from Resident #6. Regional Nurse stated CNA E had reported to LVN D that Resident #6 needed her patches replaced. Regional Nurse stated LVN D went to see and saw that it was not a callus and already an open wound. Regional Nurse stated LVN D stated it was neglect on LVN C's part. Regional Nurse stated to LVN D, What do you mean it was neglect? Regional Nurse stated it was a callus and fell off. Regional Nurse stated she had told LVN D to let her take a look at LVN Cs notes for the wound care. Regional Nurse stated LVN C had noticed that Resident #6 had a change in her callus and orders were given for that change during wound care. Regional Nurse stated Administrator suspended LVN C and she looked into the alleged allegation. Regional Nurse stated it was not reportable to state agency after confirming it was not true.</p> <p>During an interview on 03/19/24 at 3:03 PM, with the Administrator, she stated the alleged allegation made by LVN D was not reported to state agency because the investigation determined it was unsubstantiated. The Administrator stated the facility had 24 hours to investigate to determine if it happened or not. The Administrator stated if it did happen, they would report to state agency, but since it was unconfirmed it was not reported. The Administrator stated she did not believe there would be a negative outcome from not reporting to the state agency. The Administrator stated after reviewing the facility abuse, neglect policy and provider letter 19-17 it still did not require a notification to state agency.</p> <p>During an interview on 03/19/24 at 5:09 PM, with the DON, she stated LVN C was suspended due to an allegation made by LVN D regarding Resident #6. The DON stated that it did not require to be reported to state agency as the investigation concluded no wrongdoing of neglect. The DON stated even reviewing the facility abuse, neglect policy and the provider letter 19-17, it still did not require to be reported to state.</p> <p>During an interview on 03/20/24 at 11:21 AM, with the Area Director of Operations, she stated LVN C was suspended and was aware of the allegation of neglect made. The Area Director of Operations stated it was investigated by the Administrator, herself, and the Regional Nurse and found there to be no neglect by LVN C to Resident #6. The Area Director of Operations stated it was not reported to state agency. The Area Director of Operations stated no it should have not been reported to state as there was no identification of neglect.</p> <p>Record review of LVN C's suspension - Employee Disciplinary Report dated 03/12/24, revealed, Investigatory Suspension.</p> <p>LVN C will be placed on suspension for pending allegations of neglect.</p> <p>Record review of the facility Abuse/Neglect policy dated 03/29/18, revealed, The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. The facility will provide and ensure the promotion and protection of resident rights. It was each individual's responsibility to recognize, report, and promptly investigate actual or alleged abuse, neglect, exploitation, mistreatment of resident property abuse and situations that may constitute abuse or neglect to any resident in the facility.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reporting Facility employees must report all allegations of: abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident property or injury of unknown source to the facility administrator. The facility administrator or designee will report to HHSC all incidents that meet the criteria of Provider Letter 19-17 dated 07/10/19.</p> <p>If the allegation involve abuse or result in serious bodily injury, the report was to be made within 2 hours of the allegation.</p> <p>If the allegation does not involve abuse or serious bodily injury, the report must be made within 24 hours of the allegation.</p> <p>Record review of facility Long Term Care Regulatory Provider Letter dated 07/10/19, revealed, A Nursing facility must report to HHSC the following types of incidents, in accordance with applicable state and federal requirements:</p> <p>Abuse, Neglect, Exploitation, Misappropriation, Drug Theft, Death due to unusual circumstances, Fire, Emergency situations that pose a threat to resident health and safety.</p> <p>State and federal law requires an owner or employee of nursing facility who has cause to believe that the physical or mental health or welfare of a resident has been or may be adversely affected by abuse, neglect, or exploitation caused by another person to report the abuse, neglect or exploitation. Nursing facility must report all suspected or alleged incidents involving abuse, neglect, exploitation or mistreatment of resident property. A Nursing facility must report these incidents to the HHSC CII section.</p> <p>Record review of the facility Grievances policy dated 11/02/16, revealed The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents; and other concerns regarding their Long-Term Care facility stay.</p> <p>Coordinator with state and federal agencies as necessary.</p> <p>As need, the facility will take immediate action to prevent further potential violations of any resident rights while alleged violation was being investigated.</p> <p>All grievances involving alleged violations of neglect, abuse, including injuries of unknown source, and or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the abuse preventionist.</p> <p>The facility will take appropriate corrective action in accordance with state law if the alleged violation of the resident's right was confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirmed a violation of any of these resident' rights within its area of responsibility.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46998</p> <p>Based on interview, and record review the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan for 1 (Resident #3) of 4 residents reviewed for wound care.</p> <p>Resident #3 was not given wound care as prescribed to left and right heel to cleanse with normal saline cleanser, pat dry, apply foam heel protector or abdominal pad and wrap with roll gauze dressing every Monday, Wednesday, and Friday for protection as ordered as there was no wound care performed on 03/13/24.</p> <p>This failure could affect residents by placing them at risk of deterioration of the wound.</p> <p>Findings included:</p> <p>Record review of Resident #3's face sheet dated 03/15/24, revealed, admission on 10/26/23 to the facility.</p> <p>Record review of Resident #3's facility history and physical dated 10/26/23, revealed, a [AGE] year-old male diagnosed with Diabetes Mellitus .</p> <p>Record review of Resident #3's care plan dated 01/15/24, revealed has a pressure ulcer or potential for pressure ulcer development. Administer medications as ordered. Follow facility policies/protocols for the prevention/treatment of skin breakdown. Notify nurse immediately of any new areas of skin breakdown. Open area, redness, blisters, bruises, discoloration noted during bath or daily care.</p> <p>Record review of Resident #3's physician orders dated 02/28/24, revealed, to trauma wound of the right 1st toe. Cleanse with normal saline wound cleanser, apply Medi-Honey (hastens the healing of wounds through its anti-inflammatory effects), then Hydrophera (treatment of wounds burns, ulcers, and yeast) blue foam, cover with abdominal dressing and wrap with roll gauze, secure with Med Fix tape, everyday shift. Wound care to evaluate and treat as warranted for wound of the right great toe.</p> <p>Record review of Resident #3's Weekly Skin assessment dated [DATE], revealed, open area to the right great toe, discoloration, black, red, serosanguinous drainage. Scab to the right knee.</p> <p>Record review of Resident #3's Weekly Skin assessment dated [DATE], revealed, open are to the right great toe, discoloration of black, red to affected area. Minimal serosanguinous drainage. No foul smell or purulent drainage present. No other signs and symptoms noted. Peri skin was dry. No Erythema or edema present.</p> <p>Record review of Resident #3's Weekly Skin assessment dated [DATE], revealed, Physician who was medical director of facility present and was asked to assess the patients wound. At this time order was given to floor nurse to transfer the Resident #3 to emergency room . At this time Physician F also notified.</p> <p>Wound care for Resident #3 was not observed due to Resident #3 being in the hospital.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 03/15/24 at 3:27 PM, with LVN C, he stated that the DON and him would be responsible for wound care during the weekdays. LVN C stated Resident #3 had hit his right big toe on the wall during shower time. LVN C stated Resident #3 had bleeding underneath his right big toenail. LVN C stated on 03/13/24, LVN D did not perform wound care as Resident #3 was notify him that it had not been done. LVN C stated Resident #3's dressing still had his initials from 03/12/24. LVN C stated Resident #3 had recorded LVN D, where Resident #3 had asked LVN D if he was going to do wound care and LVN D replied that he was going to go do it later and never did.</p> <p>During an interview on 03/15/24 at 4:48 PM, with NP, he stated he was informed of Resident #3 hitting his toe and having a discoloration. NP stated that wound care was ordered. NP stated on 03/13/24, Resident #3 had not had wound care done. NP stated it would have affected Resident #3 if wound care was not preformed.</p> <p>During an interview on 03/15/24 at 4:12 PM, with Physician, he stated it was reported to him that Resident #3 had bumped his foot on the wall and had a scab on the injury site. The Physician stated wound care was started last week. The Physician stated the nurses are to provide wound care. The Physician stated Resident #3 was diabetic. The Physician stated there could have been a risk to Resident #3 if physician orders were not followed. The Physician stated the wound could get worse if wound care was not provided.</p> <p>During an interview on 03/18/24 at 2:38 PM, with LVN D, he stated the nurses and LVN C needed to be providing wound care as per physician orders. LVN D stated not providing wound care as order could be a risk to the resident of the wound worsening or infection. LVN D stated he was aware on 03/13/24, that LVN C was suspended and did not provide wound care for Resident #3. LVN D stated not doing wound care would be a risk of wounds worsening.</p> <p>During an interview on 03/18/24 at 4:17 PM, with the Administrator, she stated anytime LVN C was not in the facility the nurses were expected to do wound care. The Administrator stated the DON, ADON, and nurse to nurse report was how the nurses will know to do their own wound care. The Administrator stated wound care not being done as per physician orders for the residents with wounds would be out compliance. The Administrator stated she was not clinical but said missing a day of wound care she thought would be bad. The Administrator stated Resident #3 had hit his toe in the shower wall and had a cut. The Administrator stated LVN C knew Resident #3 had a diagnoses of Diabetes Mellitus. The Administrator stated it was reported to the physician and wound care orders were given to conduct wound care.</p> <p>During an interview on 03/19/24 at 11:20 AM, with the ADON, she stated the facility does have a wound care nurse which was LVN C. The ADON stated the DON and ADON will tell the nurses that LVN C did not go into work and the nurses are expected once notified to doing the wound care. The ADON stated there could be a negative outcome if wound care was not provided which could result in the resident getting worse or sick. The ADON stated it was expected for the nurses to be following physician orders and not following physician orders could cause wounds to get worse.</p> <p>During an interview on 03/19/24 at 1:56 PM, with the Regional Nurse, she stated wound care needs to be conducted as per physician orders. Regional Nurse stated not providing wound care as prescribed could result in the missing a change in the wound care. Regional Nurse stated the DON, ADON, and the floor nurses in the weekdays when LVN C was not at work are to be doing the wound care on residents. Regional Nurse stated management would let the nurses know LVN C would not be at work.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675479	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2024
NAME OF PROVIDER OR SUPPLIER Franklin Heights Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 223 S Resler El Paso, TX 79912	
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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the facility Skin Integrity Management policy dated 10/05/16, revealed, Wound care should be performed as ordered by the physician.</p> <p>Record review of the facility Skin Assessment policy dated 08/15/24, revealed, It was the policy of this facility to establish a method whereby nursing can assess a resident's skin integrity to allow of appropriate intervention be initiated in a timely manner.</p>		