STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675479	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Franklin Heights Nursing & Rehabilitation	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)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49850 Based on observations, interviews, and record review the facility failed to provide reasonable accommodation of resident needs for one out of seven Residents (Resident #6) reviewed for resident rights. On two occasions 05/11/2024 and 05/13/2024 Resident #6 was left alone in her room on the bed without being able to reach her call light. This deficiency could put other residents who are unable to use their call lights at risk of not having their care needs met by not having access to call lights to communicate their needs. Findings Included: Review of the face sheet for Resident #6 dated 05/13/2024 revealed a [AGE] year-old female and who was admitted to the facility on [DATE], with a diagnoseis of Cerebral Palsy (a congenital disorder of movement, muscle tone, or posture), muscle weakness (decreased strength in muscles), and contracture of muscle (a permanent tightening of muscles, tendons, skin, and nearby tissues that cause joints to shorten and become very stiff) . Review of the History and Physical for Resident #6 dated 03/15/2023 revealed that she had diagnoses including Spastic quadriplegic cerebral palsy, Spinal stenosis, (osteo)arthritis, and contracture of muscle in multiple sites. Review of the Annual Minimum Data Set assessment (MDS) dated [DATE] revealed Resident #6 had no BIMS score reported on her MDS. All functional abilities and goals for everyday living were left blank. Review of the care plan for Resident #6 dated 03/13/2024 revealed she had a communication problem with impaired cognition, cerebral vascular disease, and required specialized services. She required staff to ensure/provide a safe environment: Call light in reach. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 05/11/2024 at 11:32 AM revealed that Resident #6 was in bed, alert and oriented, and her head was leaning downward towards the left side of the bed. Resident #6 asked the state surveyor to help her pick up her head as she was sliding down and not comfortable. The state surveyor asked the resident if she could use her call light, which the call light was not near a place the resident could reach. Resident #6 ' s hands were contracted and unable to use the call light. The call light was under the bed sheet near her left elbow. The state surveyor advised residents that nurses were being called and to give them a second to get into the room. The state surveyor called out for the nurse. LVN A walked in to assist Resident #6. In an interview on 05/11/2024 at 11:33 AM LVN A stated, she does use the call light to call for help and addressed/demonstrated that she could tap the call light. Resident #6 was asked to tap on the call light to see if she was able to reach it where it was located under her elbow. Resident #6 was not able to tap on the call light. The call light was moved near her pillow where the resident could tap on it with her head. Interview on 05/11/2024 at 11:35 AM Resident #6 was asked how she calls for help, stating that she used her head to tap on the call light. Resident voiced the call light was not in reach where she could reach it. She addressed that she uses her head to tap on the call light when she needs help. Observation on 05/11/2024 at 01:17 PM, Resident #6 was in bed awake and listening to music. The call light was observed under the resident's pillow. The resident stated that she could not reach the call light. In an interview and observation on 05/11/2024 at 01:24 PM with ADON, ADON assisted the state surveyor with demonstrating how the call light works under the pillow. The nurse asked the resident to tap on the call light to show how she calls for help. Resident #6 stated she cannot use her head or hand unless it is on her chest. ADOB moved the call light under the resident's chin so she could use her chin to tap on it. The call light was moved to the resident's chest, and she was then able to tap the call light. ADON demonstrated with her weight on her hand on top of the pillow while standing that it turns on, but the resident was not able to turn on call light with her head when asked to. A facility policy regarding resident rights specifically to call lights was requested and received on 05/11/2024 at 02:35pm. Review of facilities policy under Respect and Dignity states The resident has a right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43871 Based on interviews and record review the facility failed to communicate with hospice representatives for 1 of 7 (Resident #1) residents reviewed for hospice services. The facility failed to notify Hospice of Resident #1's acute glucose level increase on 05/04/24. This deficient practice could place residents who receive hospice services at risk of receiving substandard care due to miscommunication between their hospice and facility care givers. The findings included: Record review of Resident #1's face sheet dated 5/16/24 revealed an [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses of DM II (long-term condition in which the body has trouble controlling blood sugar and using it for energy), dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), and anxiety. Record review of Resident #1's physician order dated 09/27/23 revealed an order for accucheck daily for DM II, notify MD if blood glucose levels less than 70 or over 400, and symptomatic she was a full code. Record review of Resident #1's physician order dated 10/07/22 revealed order for admitted to hospice with diagnosis of hypertensive heart disease with heart failure. Record review of Resident #1's care plan dated 05/15/24 revealed focus area for DM II with hyperglycemia and interventions that included Monitor/document/report to MD PRN signs and symptoms of hypoglycemia: Sweating, Tremor, Increased heart rate (Tachycardia), Pallor, Nervousness, Confusion, slurred speech, lack of coordination, Staggering gait. Record review of Resident #1's vital signs for May 2024 revealed a blood glucose level of 349 on 05/04/24 at 5:31 am. In an interview on 5/11/24 at 12:07 pm, LVN C stated she had worked a double shift (6am-10pm) on 05/24/24 and was the nurse responsible for Resident #1. LVN C stated she had not received a report from the night shift nurse regarding Resident #1's blood glucose level 349. LVN C stated she had not checked Resident #1's vital signs therefore she was not aware of Resident #1's glucose level that morning. LVN C stated Resident #1 had been fatigued throughout the day and had an increase in thirst. LVN C stated when an acute change was noted, like an increase in glucose levels, she had been trained to report it to the Hospice nurses and document actions taken to address the increase in glucose level . (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 5/11/24 at 12:56 pm, the Hospice Nurse stated he was on call the weekend of Friday 05/03/24 through Sunday 05/05/24. The Hospice nurse stated the facility was required to report any acute changes in condition to them. The Hospice nurse stated an increase of blood glucose level out of the resident's normal range would have been something the facility should have reported. The Hospice Nurse stated they would review the residents file and either adjust medication and/or insulin and reach out to the MD and the family to see what aggressive treatment they wanted for the resident . In an interview on 5/13/24 at 9:31 am, the DON stated it was expected for the charge nurses to report an acute change in blood glucose levels. The DON stated the charge nurses should have followed up on the glucose levels with another Accu-Chek, monitor symptoms, and report to MD if glucose levels and/or symptoms kept increasing. The DON stated the nurses received training upon hire and the risks included lack of blood glucose monitoring . In an interview on 5/14/24 at 11:56 am, the Hospice NP stated the facility should report glucose levels depending on their order parameters. The NP stated if the order read to report the glucose level if lower than 70 or higher than 400 and if the resident started showing some symptoms the facility should not wait until resident's blood glucose levels were over 400. The NP stated a blood glucose level of 349 with some symptoms should have been reported for medication adjustment or insulin to be adjusted . In an interview on 05/16/24 at 1:58 pm, the Compliance Nurse stated the facility was only to report a blood glucose level to hospice if over 400. The Compliance Nurse stated that hospice would not do anything for a blood glucose level of 349. Record review of Hospice Services policy dated 02/13/2007 read in part as an end-of-life measure, the resident or responsible family member may choose to use hospice services within the facility. The resident and/or responsible party will receive comfort care. The DON or designee will be responsible for immediately notifying the hospice of any significant change in condition. Notification will be documented in the medical record.