

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 08/08/2024
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45217</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure that the resident had the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility for 1 (Resident #11) of 3 residents reviewed for resident rights.</p> <p>-The facility failed to ensure the urinary collection bag for Resident #11's catheter was covered with a privacy bag.</p> <p>This failure could place residents at risk for a loss of dignity, decreased self-worth and decreased self-esteem.</p> <p>Findings included:</p> <p>Record review of Resident #11's Admission Record dated 08/07/2024, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #11's diagnoses included neuromuscular dysfunction of bladder (unable to control bladder due to nerve damage), and history of urinary tract infections (an infection in any part of the urinary system).</p> <p>Record review of Resident #11's MDS dated [DATE], reflected a BIMS score of 15, which indicated the person is intact cognitively. Resident #11 had impairment to one side of upper extremity, and to both sides of lower extremities. Resident #11 had an indwelling catheter.</p> <p>Record review of Resident #11's Order Summary Report dated 08/07/2024, reflected an order started on 09/17/2021 to Ensure foley bag is in privacy bag while in bed or wheelchair every shift.</p> <p>Record review of Resident #11's Care Plan dated 08/07/2024, read in part Resident #11 has Suprapubic Catheter (surgically created connection between the urinary bladder and the skin used to drain urine from bladder) related to neuromuscular dysfunction of bladder. Part of the interventions included Position catheter bag and tubing below the level of the bladder and in a privacy bag.</p> <p>In an observation on 08/06/2024 at 10:55 a.m., Resident #11 was lying in bed with the bedroom door open and with the catheter collection bag attached to the frame of the bed and outside of a privacy bag viewable from the hall. Resident #11 was asleep at the time.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation and interview on 08/06/2024 at 11:01 a.m., LVN E entered Resident #11's bedroom and said the catheter collection bag should have been inside a privacy bag. LVN E said she did not know why the collection bag was not in a privacy bag. LVN E said Resident #11 had not gotten up from bed that day and required assistance for all transfers. LVN E said nurses and CNAs were responsible to ensure the collection bag was inside the privacy bag.</p> <p>In an observation and interview on 08/07/2024 at 9:09 a.m., Resident #11 was lying in bed awake eating his meal with the bedroom door open. The catheter collection bag was attached to the frame of the bed and outside of a privacy bag. Resident #11 said he had not gotten up from bed today. Resident #11 said he did not know why the collection bag was outside of the privacy bag. Resident #11 said he did not like for the collection bag to be visible for anyone passing but that staff take out the collection bag and just leave it out.</p> <p>During an interview on 08/08/2024 at 2:44 p.m., the DON said the purpose of using a privacy bag for the catheter collection bag was to provide privacy. The DON said it was the responsibility of the nurse and CNAs in the hall to ensure that the collection bag is attached to the frame and inside a privacy bag. The DON said the risk to the resident was resident privacy could be violated.</p> <p>Review of facility provided Catheter Care policy dated 02/2007, reads in part, Review the resident's plan of care daily for changes providing as much privacy as possible .</p> <p>Review of facility provided Resident Rights policy dated 11/28/2016, reads in part, The resident has a right to be treated with respect and dignity, including: the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45217</p> <p>Based on observation, interviews and record review the facility failed to ensure residents the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for 1 (Residents #10) of 6 residents reviewed for call light placement.</p> <p>-The facility failed to ensure that Residents #10's call light was within her reach.</p> <p>This failure placed residents at risk of not being able to call for assistance when needed.</p> <p>Findings included:</p> <p>Record review of Resident #10's Admission Record dated 08/07/2024, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #10's diagnoses included cerebral palsy (congenital disorder of movement, muscle tone, or posture), vascular dementia (problems with reasoning, planning, judgment, memory and other thought processes caused by brain damage from impaired blood flow to the brain), major depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), mild intellectual disabilities (deficits in theoretical thinking/learning), paraplegia (paralysis that affects your legs, but not your arms) and contracture of muscle, right hand.</p> <p>Record review of Resident #10's quarterly MDS dated [DATE], revealed a BIMS score of 01 indicating severe cognitive impairment. Resident #10 had impairment to both sides of her upper and lower body. Resident #10 was dependent on staff assistance with eating, oral hygiene, toileting, bathing, dressing, personal hygiene, and transferring.</p> <p>Record review of Resident #10's care plan dated 08/07/2024, read in part Resident #10 had communication problem related to impaired cognition Cerebral Vascular Disease. Part of the interventions included Ensure/provide a safe environment: Call light in reach. Another focus area reads in part that Resident #10 had potential fluid deficit related to physical limitation. Part of the intervention included Keep fluids at bed side and offer fluids as much as possible. Resident #10 needs assistance with fluid intake in order to meet daily requirements.</p> <p>During an observation and interview on 08/06/2024 at 10:42 a.m., Resident #10 was lying in bed with her call button clipped onto the cord near the call light outlet. Resident #10's cup of water was on top of dresser approximately three feet away from the resident. Resident #10 said she could not reach the call button to call for help because her hand was contracted. Resident #10 said she was able to press the call pad button when she needed assistance, but someone left the button out of her reach. Resident #10 said she needs staff assistance when she wants water but could only do so using her call button which she could not reach. Resident #10 said the water was not within her reach. Resident #10 said she was given a shower in the morning and the staff returned her to bed and left her call button out of her reach. Resident #10 said she did not know how long the button had been out of her reach.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation and interview on 08/06/2024 at 10:44 a.m., LVN C entered Resident #10's bedroom and said Resident #10 had just been showered about 20 minutes before. LVN C said the CNAs brought Resident #10 back to her room and must have left the call button out of her reach. LVN C said Resident #10 was not in any distress or no signs of dehydration. LVN C said because resident was so contracted, the resident would have to call staff to help her get water.</p> <p>During an observation and interview on 08/06/2024 at 10:46 a.m., CNA E entered Resident #10's bedroom and said she assisted the other CNA in the hall to take Resident #10 to get a shower. CNA E said Resident #10 was assisted back to her room about 20 minutes ago and was transferred to her bed. CNA E said they must have forgotten to clip Resident #10's call pad within resident's reach. CNA E said resident was able to use the call pad to call for assistance when needed.</p> <p>During an interview on 08/08/2024 at 2:44 p.m., the DON said the purpose of the call button was for patients to call for staff assistance. The DON said she was familiar with Resident #10. The DON said Resident #10 was able to use the call light to call for assistance. The DON said the call light must be in reach of the resident. The DON said nurses and CNAs are responsible to ensure that the call button was in reach of the residents. The DON said the risk of the call button being out of reach of Resident #10 was that she would be unable to call for help or assistance including getting assistance with getting water. Surveyor requested a copy of the call light policy.</p> <p>Review of facility provided Resident Rights policy dated 11/28/2016, reads in part, The resident has a right to be treated with respect and dignity, including: the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.</p> <p>On 08/08/2024 at 2:44 p.m., the Surveyor requested copy of call light policy. The policy was not provided prior to exit.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45217</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents who are incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 (Resident #11) of 3 residents reviewed for catheter care.</p> <p>-The facility failed to ensure Residents #11's catheter leg strap was in place to secure the catheter.</p> <p>This failure could place residents with foley catheters at risk of catheter pulling causing pain.</p> <p>Findings included:</p> <p>Record review of Resident #11's Admission Record dated 08/07/2024, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #11's diagnoses included neuromuscular dysfunction of bladder (unable to control bladder due to nerve damage), and history of urinary tract infections (an infection in any part of the urinary system).</p> <p>Record review of Resident #11's MDS dated [DATE], reflected a BIMS score of 15, which indicated the person is intact cognitively. Resident #11 had impairment to one side of upper extremity, and to both sides of lower extremities. Resident #11 required total assistance with toileting hygiene, and substantial/maximal assistance with bathing, dressing, and transfers. Resident #11 had an indwelling catheter.</p> <p>Record review of Resident #11's Order Summary Report dated 08/07/2024, reflected an order started on 09/17/2021 to Ensure catheter strap in place and holding every shift change as needed.</p> <p>Record review of Resident #11's Care Plan dated 08/07/2024, reads in part Resident #11 has Suprapubic Catheter related to neuromuscular dysfunction of bladder. Part of the interventions included Ensure tubing is anchored to the resident's leg or linens so that tubing is not pulling on the urethra.</p> <p>During an observation and interview on 08/07/2024 at 9:09 a.m., Resident #11 was lying in bed. Surveyor visited resident with LVN E. LVN E asked Resident #11 if she could see the catheter strap and resident agreed. LVN E observed there was no catheter strap in place anchored to the resident's leg or linen. LVN E said it should have been a piece of tape holding the catheter tubing. LVN E said there was no sign or any tape or any other securement in place. LVN E said the risk to Resident #11 was the catheter could be pulled out causing pain and discomfort. Resident #11 said he had not had the catheter pulled out while at the facility. LVN E said she was the nurse for the hall since 6:00 a.m. and did not know how long Resident #11 did not have a catheter strap on. LVN E said she checks for the securing/placement of the catheter strap every shift.</p> <p>(continued on next page)</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 08/08/2024 at 2:44 p.m., the DON said the purpose of the catheter strap was to hold the tubing in place. The DON said the placement of the strap was monitored by nursing per shift. The DON said Resident #11 had not had the catheter pulled out while at the facility. The DON said Resident #11 had personal history of UTIs but had not had one at the facility. The DON said the risk of not having the catheter strap in place was the catheter being pulled out which could cause pain and trauma.</p> <p>Review of facility provided Catheter Care policy dated 02/2007, reads in part, Check the resident frequently to be sure he or she is not lying on the catheter and to keep the catheter and tubing free of kinks .minimize friction or movement at insertion site.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45217</p> <p>Based on observation, interview, and record review, the facility failed to ensure that residents who needed respiratory care were provided such care, consistent with professional standards of practice, for 1 (Resident #12) of 3 the residents reviewed for respiratory care.</p> <p>-The facility failed to ensure Residents #12 did not have an empty oxygen humidifier bottle on the oxygen concentrator dated 07/20/2024 while in use.</p> <p>This deficient practice could place residents who received oxygen therapy at risk for an increase in respiratory complications.</p> <p>Findings included:</p> <p>Record review of Resident #12's Admission Record dated 08/07/2024, revealed an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #12's diagnoses included pulmonary hypertension (type of high blood pressure that affects arteries in the lungs and in the heart), chronic obstructive pulmonary disease (lung disease that block airflow and make it difficult to breathe), pulmonary fibrosis (lung disease that occurs when lung tissue becomes damaged and scarred) and chronic respiratory failure with hypoxia (condition where you don't have enough oxygen in the tissues in your body).</p> <p>Record review of Resident #12's initial MDS dated [DATE], revealed a BIMS score of 08 indicating moderate cognitive impairment. Resident #12 had impairment to both lower extremities. Resident #12 was on oxygen therapy.</p> <p>Record review of Resident #12's Order Summary Report dated 08/07/2024, revealed an order May use oxygen at 2 l/m via nasal canula every shift.</p> <p>During an observation and interview on 08/06/2024 at 10:58 a.m., Resident #12 was lying down in bed with nasal cannula on. Resident's oxygen concentrator at bedside with the humidifier bottle empty, dated 07/20/2024. Resident #12 said she did not know why her humidifier bottle was empty. Resident #12 said she did not know how long the humidifier had been empty. Resident #12 said she was not in any distress at the time.</p> <p>During an interview on 08/06/2024 at 11:04 a.m., LVN E said the oxygen concentrator humidifier bottle should have had water in it. LVN E acknowledged that the bottle was empty and said she was going to get water for the oxygen. LVN E said the water was needed to humidify the oxygen for Resident #12. LVN E said she did not know why the bottle was dated 07/20/2024 and said she knows that the bottle had water in it the day before. LVN E said she did not know why the bottle was empty. LVN E said it was her responsibility to check the oxygen concentrator while making rounds during her shift to verify there was water and said she must have overlooked the bottle today.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 08/08/2024 at 2:44 p.m., the DON said the purpose of the oxygen concentrator humidifier was to humidify the oxygen going into the nose of the resident. The DON said she was not sure of the date written on the humidifier and why the date of 07/20/2024 was written on it. The DON said Resident #12 had not experienced any respiratory distress. The DON said the nurse assigned to the hall was the responsible person to check on the humidifier bottle while making rounds during their shift. The DON stated that residents risked possible dry nasal passages by having her oxygen humidifier bottle empty for Residents #12.</p> <p>Review of facility provided Oxygen Administration policy dated 03/21/2023, reads in part, Oxygen therapy includes the administration of oxygen in liters/minute by cannula or face mask to treat hypoxemic conditions caused by pulmonary or cardiac diseases. Under Procedures includes: Fill the humidifier container to the marked level with distilled water and attach to the cylinder.</p>		