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	11/25/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to develop and implement a comprehensive person-centered care plan that includes measurable objectives and time frames to meet a resident's medical and nursing needs for 1 of 7 residents (Resident #1) reviewed for care plans.The facility failed to implement Resident #1's comprehensive person-centered care plan on 11/11/2025, for medication administration. This deficient practice could place residents in the facility at risk of not receiving the necessary care or services and not having personalized plans developed to address their needs.The findings included: Record review of Resident #1's face sheet dated 11/20/2025 revealed an [AGE] year-old male who was originally admitted to the facility on [DATE]. Record review of Resident #1's history and physical dated 7/5/25, revealed that Resident #1 was admitted to a local hospital on 06/18 with altered mental status and neglect concerns. Resident #1 was diagnosed with a left middle cerebral artery (MCA) stroke (blocked blood flow to the brain), urinary tract infection (infection of the urinary system), and metabolic encephalopathy (confusion due to infection and chemical imbalance). Due to dysphagia (inability to swallow safely), the resident underwent placement of a PEG tube (feeding tube placed directly into the stomach) on 07/03, which was required for enteral nutrition and medication administration due to unsafe oral intake. Record review of Resident #1's quarterly MDS dated [DATE] revealed a BIMS score of 07, indicating moderately impaired cognition. Review of Section GG indicated the resident required substantial assistance with self-care and mobility and was dependent on staff for multiple activities of daily living due to limited physical and cognitive functioning. The MDS documented that the resident had impaired swallowing ability and required altered nutritional support due to his inability to safely swallow food or medications. The MDS Section K for swallowing and nutritional status, paragraph B reflected that the resident had a feeding tube, indicating that oral intake was not safe and that enteral feeding (providing nutrition, fluids and medications directly into the stomach or intestines through a feeding tube) methods were required. Record review of Resident #1's care plan dated 10/13/2025 revealed that the resident required tube feeding related to dysphagia (trouble with swallowing) and was dependent on a PEG tube (a tube placed through the belly into the stomach so a person can get food, water, and medications when they cannot safely eat or swallow by mouth) for nutrition, hydration, and medication administration. The care plan revealed that the resident was not safe for oral intake and required staff to administer feedings and medications through the PEG. The care plan directed staff to monitor tube placement, perform daily site care, keep the head of bed elevated during and after feedings, and monitor for complications including aspiration (when food, liquid, or saliva accidentally enters the lungs, which can cause choking), infection, tube dislodgement (when the feeding tube comes out of place or gets pulled out), and intolerance of feedings. In an interview on 11/19/2025 at 10:32 AM, Resident #1 stated a nurse had given him the wrong medication. Resident #1 stated that he did not know which medication it was, only that it was a white pill and a pink pill, and that the nurse placed the medication in his mouth for him to swallow. Resident #1 stated that his medications was supposed to be administered through his PEG tube per doctor's orders because it was not safe for him to swallow pills. The Resident said he told the staff he did not want the medications, but the nurse insisted he needed to take them, so he swallowed the pills. Resident #1 stated that after the staff gave him these medications, he reported the incident to a different nurse to make sure the right medications were being given to him. Resident #1 stated that after reviewing the medications he was supervised with, the nurse took him to the DON to report a medication error. Resident #1 stated that the staff monitored him for five days to make sure he did not develop complications from receiving the wrong medications. In an interview on 11/19/2025 at 10:55 AM with LVN A, he stated that when a resident is administered with medications by a CMA (certified medication assistant), the CMA is required to review the resident's medication orders and care plan to make sure they are following the physician's instructions. LVN A stated that failing to review a resident's care plan or medical record before giving medications could result in the resident receiving medications in a manner that is not consistent with their care needs. LVN A stated that not following a resident's care plan could lead to medication errors, a decline in the resident's condition, and the resident becoming ill if the wrong medications were given. In an interview on 11/19/2025 at 12:37 PM, the NP stated the medication error involving Resident #1 occurred because staff did not follow the resident's medication orders or his documented care plan. The NP stated that all CMAs, LVNs, and RNs was responsible for checking the resident's care plan before administering any medication to make sure the

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 7 (Resident #1) reviewed for pharmacy services. The facility failed to follow physician's order by administering Amiodarone (a heart medication used to control dangerous irregular heartbeats) to Resident #1 when he was not prescribed this medication. This failure placed the residents at risk of not receiving their medications as ordered by the physician, which could cause a serious allergic reaction and side effects.The findings included: Record review of Resident #1's face sheet dated 11/20/2025 revealed an [AGE] year-old male who was originally admitted to the facility on [DATE]. Record review of Resident #1's history and physical dated 7/5/25, revealed that Resident #1 was an [AGE] year-old male admitted to a local hospital on 06/18 with altered mental status and neglect concerns. Resident #1 was diagnosed with a left middle cerebral artery (MCA) stroke (blocked blood flow to the brain), urinary tract infection (infection of the urinary system), and metabolic encephalopathy (confusion due to infection and chemical imbalance). Due to dysphagia (inability to swallow safely), the resident underwent placement of a PEG tube (feeding tube placed directly into the stomach) on 07/03, which was required for enteral nutrition and medication administration due to unsafe oral intake. Record review of Resident #1's quarterly MDS dated [DATE] revealed a BIMS score of 07, indicating moderately impaired cognition. Review of Section GG indicated the resident required substantial assistance with self-care and mobility and was dependent on staff for multiple activities of daily living due to limited physical and cognitive functioning. The MDS documented that the resident had impaired swallowing ability and required altered nutritional support due to his inability to safely swallow food or medications. The MDS Section K for swallowing and nutritional status, paragraph B reflected that the resident had a feeding tube, indicating that oral intake was not safe and that enteral feeding (providing nutrition, fluids and medications directly into the stomach or intestines through a feeding tube) methods were required. Record review of Resident #1's care plan dated 10/13/2025 revealed that the resident required tube feeding related to dysphagia and was dependent on a PEG tube (feeding tube placed directly into the stomach) for nutrition, hydration, and medication administration. The care plan documented that the resident was not safe for oral intake and required staff to administer feedings and medications through the PEG tube. The care plan directed staff to monitor tube placement, perform daily site care, keep the head of bed elevated during and after feedings, and monitor for complications including aspiration, infection, tube dislodgement, and intolerance of feedings. Record review of the facility's Employee Disciplinary Report dated 10/16/2025, revealed CMA B was placed on an investigatory suspension pending an investigation into allegations of administering Resident # 1 the wrong medication. The form was signed by the Human Resources staff and CMA B on 10/16/25. In an interview on 11/19/2025 at 10:41 AM Resident #1stated that a nurse had given him the wrong medication. Resident #1 stated that he did not know which medication it was, only that it was a white pill and a pink pill, and that the nurse placed the medication in his mouth for him to swallow. Resident #1 stated that his medications were supposed to be administered through his PEG tube per doctor's orders because it was not safe for him to swallow pills. The Resident said he told the staff he did not want the medications, but the nurse insisted he needed to take them, so he swallowed the pills. Resident #1 stated that after the staff gave him these medications, he reported the incident to a different nurse to make sure the right medications were being given to him. Resident #1 stated that after reviewing the medications he was supervised with, the nurse took him to the DON to report a medication error. Resident #1 stated that the staff monitored him for five days to make sure he did not develop complications from receiving the wrong medications. In an interview on 11/19/2025 at 10:55 AM, LVN A stated that CMAs (certified medication assistants) must verify a resident's medication orders before administering any medications to prevent medication errors. LVN A stated that reviewing the resident's care plan is also required to ensure medications are being given exactly as prescribed by following the seven R's that included the right dose, route, resident, medication, time and documentation. LVN A stated that when staff do not check the orders or the care plan, the risk of a medication error increases, which could cause the resident's health to worsen or make the resident sick if incorrect medication is administered. In an interview on 11/19/2025 at 12:37 PM, the NP stated that the resident experienced a medication error when he was given Amiodarone (a strong heart-rhythm medication used to treat dangerous irregular heartbeats) and

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to prevent significant medication errors for 1 of 7 residents (Resident #1) reviewed for pharmacy services. The facility failed to follow physician's order by administering Amiodarone (a heart medication used to control dangerous irregular heartbeats) to Resident #1 when he was not prescribed this medication. This failure placed the residents at risk of not receiving their medications as ordered by the physician, which could cause a serious allergic reaction and side effects.The findings included: Record review of Resident #1's face sheet dated 11/20/2025 revealed an [AGE] year-old male who was originally admitted to the facility on [DATE]. Record review of Resident #1's history and physical dated 7/5/25, revealed that Resident #1 was an [AGE] year-old male admitted to a local hospital on 06/18 with altered mental status and neglect concerns. Resident #1 was diagnosed with a left middle cerebral artery (MCA) stroke (blocked blood flow to the brain), urinary tract infection (infection of the urinary system), and metabolic encephalopathy (confusion due to infection and chemical imbalance). Due to dysphagia (inability to swallow safely), the resident underwent placement of a PEG tube (feeding tube placed directly into the stomach) on 07/03, which was required for enteral nutrition and medication administration due to unsafe oral intake. Record review of Resident #1's quarterly MDS dated [DATE] revealed a BIMS score of 07, indicating moderately impaired cognition. Review of Section GG indicated the resident required substantial assistance with self-care and mobility and was dependent on staff for multiple activities of daily living due to limited physical and cognitive functioning. The MDS documented that the resident had impaired swallowing ability and required altered nutritional support due to his inability to safely swallow food or medications. The MDS Section K for swallowing and nutritional status, paragraph B reflected that the resident had a feeding tube, indicating that oral intake was not safe and that enteral feeding (providing nutrition, fluids and medications directly into the stomach or intestines through a feeding tube) methods were required. Record review of Resident #1's care plan dated 10/13/2025 revealed that the resident required tube feeding related to dysphagia and was dependent on a PEG tube (feeding tube placed directly into the stomach) for nutrition, hydration, and medication administration. The care plan documented that the resident was not safe for oral intake and required staff to administer feedings and medications through the PEG tube. The care plan directed staff to monitor tube placement, perform daily site care, keep the head of bed elevated during and after feedings, and monitor for complications including aspiration, infection, tube dislodgement, and intolerance of feedings. Record review of the facility's Employee Disciplinary Report dated 10/16/2025, revealed CMA B was placed on an investigatory suspension pending an investigation into allegations of administering Resident # 1 the wrong medication. The form was signed by the Human Resources staff and CMA B on 10/16/25. In an interview on 11/19/2025 at 10:41 AM Resident #1stated that a nurse had given him the wrong medication. Resident #1 stated that he did not know which medication it was, only that it was a white pill and a pink pill, and that the nurse placed the medication in his mouth for him to swallow. Resident #1 stated that his medications were supposed to be administered through his PEG tube per doctor's orders because it was not safe for him to swallow pills. The Resident said he told the staff he did not want the medications, but the nurse insisted he needed to take them, so he swallowed the pills. Resident #1 stated that after the staff gave him these medications, he reported the incident to a different nurse to make sure the right medications were being given to him. Resident #1 stated that after reviewing the medications he was supervised with, the nurse took him to the DON to report a medication error. Resident #1 stated that the staff monitored him for five days to make sure he did not develop complications from receiving the wrong medications. In an interview on 11/19/2025 at 10:55 AM, LVN A stated that CMAs (certified medication assistants) must verify a resident's medication orders before administering any medications to prevent medication errors. LVN A stated that reviewing the resident's care plan is also required to ensure medications are being given exactly as prescribed by following the seven R's that included the right dose, route, resident, medication, time and documentation. LVN A stated that when staff do not check the orders or the care plan, the risk of a medication error increases, which could cause the resident's health to worsen or make the resident sick if incorrect medication is administered. In an interview on 11/19/2025 at 12:37 PM, the NP stated that the resident experienced a medication error when he was given Amiodarone (a strong heart-rhythm medication used to treat dangerous irregular heartbeats) and Vitamin B12 (a vitamin used for anemia and nerve function), even though he was not prescribed either