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	11/26/2025

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 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. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure resident was free from any physical or chemical restraints imposed for purposes of discipline or convenience for two (Resident #4 and Resident #5) of three residents reviewed for freedom from physical restraints. The facility failed to ensure Residents #4, and Resident #5 did not have pillows under their mattresses which restricted his movement from getting off the bed and were not required to treat his medical symptoms. This failure could put residents at risk of unnecessary restriction of their movements. Resident #4 Record review of Resident #4's face sheet dated 10/24/2025, revealed, admission on [DATE] to the facility. Resident #4 was a [AGE] year-old female diagnosed with Alzheimer's disease, abnormal posture and gait, neurocognitive disorder with Lewy bodies dementia (proteins that disrupt normal brain function), cognitive communication deficit (difficulties in communication), schizophrenia (brain disorder that affects how the brain processes information), major depressive disorder (sadness, hopelessness, and lack of activities), history of COVID-19 (Coronavirus, similar to a common cold, some cases can lead to respiratory distress), protein-calorie malnutrition (does not get enough protein and calories to maintain proper health), insomnia (lack of sleep), generalized muscle weakness (muscles can't work as hard as they should), anxiety (feeling of worry, nervousness, or fear), hypothyroidism (thyroid gland that does not make enough hormones), age related osteoporosis (bones that are weaker and more likely to break), hypertension (high blood pressure), peripheral vascular disease (circulation of the blood vessels), and Tourette's disorder (uncontrollable movement or sounds known as tics). Record review of Resident #4's admission MDS dated [DATE], revealed a severely impaired cognition BIMS score of 00 to be able to recall or make daily decisions. Functional abilities self-performance revealed extensive assistance (staff provides weight-bearing support assistance) for rolling left or right in bed, sitting to lying, lying to sitting on side of bed. Resident #4 was limited assistance (staff provided guided maneuvering of limbs or other non-weight- bearing assistance) for transfers from bed to chair, wheelchair, standing position. Record review of Resident #4's History and Physical, dated 07/08/2025, revealed, readmission to acute hospital secondary to a fall sustaining an acute fracture of the right femur neck (a hip fracture). Record review of Resident #4's care plan dated 05/19/2025, revealed, ADLs for bed mobility/transfers requiring supervision as needed. At a high risk for falls unaware of safety needs, ambulates without walker. Interventions to supervise closely and make regular compliance rounds whenever the resident was in room. Pillows were not care planned to prevent falls for Resident #4. Care plans had no medically needed devices indicating the Resident needed a pillow or device tucked into the bed sheet. During an observation and interview on 10/24/2025 at 10:00am, revealed Resident #4 was lying in bed. The surveyor went up to Resident #4 who was lying next to a long body pillow that was tucked underneath Resident's bed sheets. Attempted an interview with Resident #4 and the only response was hello. In an interview on 10/24/2025 at 10:09 am, CNA A stated she had been working at the facility for 9 months and worked the morning shift. CNA A stated she was trained on restraints. The last training was last month in September 2025 and was instructed not to add any barriers to Residents that don't allow them from moving freely especially Residents who were fall risk. CNA A walked to Resident #4's room where she witnessed the pillow tucked underneath the bed sheet and Resident #4 lying in bed. CNA A stated, The pillow is used to keep the resident from falling out of the bed because the resident is a constant mover and staff does not want the resident to fall. So, they either place a triangle holder but when staff do not have one, staff will add pillows. CNA A stated fall precautions used where the bed was to the lowest position, floor mats in place, and call lights in reach for all residents. In an interview on 10/24/2025 at 02:25pm the DON was presented with pictures showing Resident #4 with pillows tucked under her bed sheets. The DON stated that the procedure was used to be for repositioning the patient if medically needed. The DON stated that Resident #4 was still capable of getting out of her bed so the pillow being inserted under the bedsheet was not a restraint, but all staff took training on not inserting pillows under bedsheets. Resident #4 does not need any device or pillow for medical needs. In an interview on 10/24/2025 at 02:38 PM, LVN B stated she was the LVN and charge nurse and worked only Monday-Friday from 6AM-2pm. LVN B was shown a picture that had been taken by the surveyor during rounds showing the pillows tucked underneath the bed sheets of residents to prevent them from falling. LVN B stated that the picture showing the pillow tucked under the bed sheets was considered a restraint. LVN B stated that the facility had trained all staff not to do that (referring to the pillow