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	01/09/2026

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 - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the resident resided and received services in the facility with reasonable accommodation of resident needs and preferences for 5 (Resident # 2, Resident # 5, Resident # 6, Resident #7 and Resident #8) of 8 residents reviewed for accommodation of needs. The facility failed to ensure Residents #2, #5, #6, #7 and #8, had their call lights within reach.This failure could place residents at risk for not having their needs/preferences met.Findings included:1. Record review of Resident #2's admission Record, dated [DATE] revealed an admission date of [DATE] and re-admission date of [DATE].Record review of Resident #2's Physician's Progress Note, dated [DATE], revealed a [AGE] year-old male with medical history of diabetes mellitus (a chronic condition where the body does not produce enough insulin or cannot use insulin effectively), multiple CVAs (a stroke, causing blood flow to part of the brain gets cut off, starving brain cells of oxygen and causing them to die) with residual left sided weakness, mental illness (refer to health conditions that involve changes in emotion, thinking, or behavior), HTN (when the force of blood pushing against the artery wall is consistently too high, making the heart work harder and straining blood vessels, which increases the risk of heart attack and stroke), left below the knee amputation, status post right foot first toe amputation.Record review of Resident #2's Annual MDS Assessment, dated [DATE], revealed, clear speech, made self-understood, BIMS Summary Score 15 (cognitively intact), toileting substantial/maximal assistance, frequently incontinent of urine, incontinent of bowel, dependent with chair/bed transfer; limitation in range of motion on one side to upper/lower extremity; mobility device - wheelchair; CVA, arthritis; frequently had pain at numeric rating scale of 7 in a pain scale from 1-10, 10 being the worst pain.Record review of Resident #2's Care Plan, dated [DATE], revealed the resident incontinent of bowel and bladder, had a Cerebral Vascular Accident (Stroke), and ADL self-care deficit. The care plan revealed encouraged the resident to use the bell to call for assistance.Record review of Resident #2's Physician Order Summary Active Orders as of [DATE] revealed, Start Date: [DATE] OT for skilled services to include self-care, therapeutic exercises, wheelchair management, for generalized weakness. OT TX Order, dated [DATE], revealed ADL retraining to increase BUE strength, facilitate postural control, improve dynamic sitting balance, increase independence in functional transfer, and increase functional activity tolerance in order to increase independence in ADLs.Record review of Resident #2's Visual/Bedside electronic report revealed, Safety: Encouraged the resident to use bell to call for assistance.During an interview on [DATE] at 12:10 p.m., Social Worker B revealed Resident #2 was oriented to person, place, and time, required total assistance with ADLs, incontinent of bowel and bladder, required two people to turn & reposition in bed. He said the resident was able to use the call light for assistance.During an interview on [DATE] at 1:47 p.m. LVN Charge Nurse G, assigned to Resident #2 on the morning shift, revealed the resident was alert, oriented to person, place, and time, required assistance of two people to turn and reposition in bed, incontinent of bowel (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 - Some	and bladder and used a disposable brief, and was able to use the call light to ask for assistance to use the urinal and/or bed pan. She said they were trained to keep call lights within reach and licensed staff randomly made rounds to check call lights were placed within residents reach. She said Resident #2 had paralysis to the left side of the body with a below the knee amputation to the left lower leg and limited range of motion to the right arm. She said the nursing staff were trained to place the call lights within reach, and all staff were responsible for checking the call lights to ensure they were always kept within reach. She said Resident #2 was occasionally confused and at times used the call light for assistance to turn & reposition in bed or to use the urinal and/or bed pan.During an observation and interview on [DATE] at 9:25 a.m., Resident #2 was lying in bed awake, with the head of the bed raised at approximately 45 degrees, the call light clipped to the side of the head of the bed on his right side. Resident #2 demonstrated to the state surveyor that he could reach the call light but had difficulty reaching the call due to limited movement to his right arm and could not see where the call light was clipped on the head of the bed. He said, It's hard to reach the call light at times, but I do not like for them to clip the call light to my gown because it pinches my chest when I move in bed. Resident #2 demonstrated to the state surveyor that he had paralysis on his left side and could not use his left arm. During an interview on [DATE] at 10:06 a.m., LVN MDS Nurse M revealed Resident #2 was oriented to person, place and recognized familiar faces. He said the resident was able to use his call light for assistance. He said nursing staff were trained to place the call lights within reach, and all staff were responsible for checking the call lights to ensure they were always kept within residents' reach.During a telephone interview on [DATE] at 12:56 p.m. CNA P revealed Resident #2 was oriented to person, place, and time, required total assistance with ADLs, required assistance of two people to turn and reposition in bed, was incontinent of bowel and bladder, used a disposable brief, and could use his call light to request assistance. She said the CNAs were trained to place the call lights within reach, and all staff were responsible for checking the call lights to ensure they were always kept within residents' reach.During an interview on [DATE] at 12:57 p.m., CNA L revealed Resident #2 was oriented to person, place, and recognized familiar faces. She said Resident #2 was able to use his call light for assistance. She said the nursing staff were trained to place the call lights within reach, and all staff were responsible for checking the call lights to ensure they were always kept within residents' reach.During a telephone interview on [DATE] at 1:25 p.m., CNA Q revealed Resident #2 was oriented to person, place, and time, required total assistance with ADLs, had paralysis on the left side, below the knee amputation on the left leg, required assistance of two people to turn and reposition in bed, was incontinent of bowel and bladder, used a disposable brief, and could use his call light to request assistance. She said the CNAs were trained to place the call lights within reach, and all staff were responsible for checking the call lights to ensure they were always kept within residents' reach.2. Record review of Resident #6's admission Record dated [DATE] revealed an admission date of [DATE].Record review of Resident #6's History & Physical, dated [DATE], revealed an [AGE] year-old female with a history of Parkinsons Disease (a brain disorder that makes it hard to control movements, causing symptoms like tremors, stiffness, slow movements, and balance problems because the brain does not produce enough dopamine, a crucial chemical for smooth motion. This is a progressive condition, causing symptoms to worsen overtime.), dementia (a general term for a group of brain disorders that cause a gradual decline in cognitive abilities such as memory, thinking, language, problem-solving, judgement, and orientation), arthritis (general term for joint pain or joint disease meaning inflammation or swelling in one or more joints causing pain, stiffness and reduced movement often impacting daily activities) and (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	oriented to person.Record review of Resident #6's Quarterly MDS, dated [DATE], revealed clear speech, made self-understood, understood others, impaired vision, BIMS Summary Score three (cognitively severely impaired), incontinent of bowel & bladder, Non-Alzheimer's Dementia (losing the thinking, memory, and social skills enough to mess up daily life), Parkinson's Disease, cognitive communication deficit (difficulty with talking or understanding due to problems with thinking skills like attention, memory, problem solving or reasoning. Rather than a problem with the mouth or voice itself, often resulting from brain injury or conditions and affecting social interactions, organizing thoughts and following conversations).Record review of Resident #6's Care Plan, revised [DATE], revealed Resident #6 was incontinent of bowel and bladder, had Parkinson's Disease, alteration in musculoskeletal status r/t osteoarthritis (wearing out of the cartilage from age or use, causing bone to rub, leading to pain, stiffness, swelling, and grinding sounds, especially in hands, knees, hips, and spine, making movement difficult as it slowly breaks down the joint tissue over time) Interventions included anticipate and meet needs; be sure call light was within reach, encouraged the resident to use the call light and respond promptly to all requests for assistance. Resident #6 had impaired cognitive function r/t Dementia, had impaired vision, was ADL deficit, at risk for falls r/t difficulty in walking, muscle weakness, and Parkinson's (a brain disorder that makes it hard to control movements, causing symptoms like tremors, stiffness, slow movements, and balance problems because the brain does not produce enough dopamine, a crucial chemical for smooth motion. This is a progressive condition, causing symptoms to worsen overtime).During an observation and interview on [DATE] at 9:20 a.m., revealed Resident #6 was lying in bed eating breakfast. It was observed that the call light was clipped to the side of the pillowcase, slightly under the pillow and was not within reach of the resident. The resident was oriented to person, and place. Resident #6 said she used her call light for assistance. When the surveyor asked the resident if she could reach the call light, she said no. The resident said the staff usually clipped the call light next to the side of the bed close to her arm to be able to reach the call light to call for assistance.During an observation and interview on [DATE] at 9:23 a.m., Medication Aide J was in the hallway close to Resident #6's room. Med Aide J said Resident #6 was alert, oriented to person and place, and was able to use her call light for assistance. She said she administered Resident #6's medications at 9:00 a.m. that morning and had not noticed the call light was not within reach. Resident #6 was still eating her breakfast in bed. The Med Aide J placed the resident call light within reach by clipping it to the side of the bed, close to the resident's right arm. She said the nursing staff was trained to place the call lights within reach, and all staff were responsible for checking the call lights to ensure they were always kept within residents' reach.During an interview on [DATE] at 9:32 a.m., LVN N revealed Resident #6 was alert, oriented to person, place, and was confused at times. She said she did not know if the resident was able to use her call light. She said the resident yelled out when she needed help. She said, I check during rounds that call lights are kept within reach. She said she did not know who served the breakfast tray to Resident #6 this morning ([DATE]). She said the nursing staff were trained to place the call lights within reach, and all staff were responsible for checking the call lights to ensure they were always kept within residents' reach.During an interview on [DATE] at 10:08 a.m. LVN MDS Nurse M revealed Resident #6 was oriented to person and place. He said Resident #6 used her call light at times for assistance.3. Record review of Resident #5's admission Record dated [DATE], revealed an admission date [DATE] and re-admission date of [DATE]. Record review of Resident #5's Quarterly MDS, dated [DATE], revealed clear speech, usually makes self-understood, usually understood others, impaired vision, BIMS Summary Score six (cognitively severely impaired), independent with mobility, frequently (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	incontinent of urine, occasionally incontinent of bowel, depression, diabetes mellitus, mood disorder, vascular dementia, and repeated falls.Record review of Resident #5's Care Plan, revised [DATE], revealed Resident has impaired cognitive function or impaired thoughts r/t Dementia. Resident had and Activities of Daily Living self-care deficit r/t to impaired cognition. Resident had a communication problem r/t cognitive impairment. Resident had hearing loss. Resident Was incontinent of bowel & bladder. Resident at risk for falls r/t muscle weakness, unsteady gait, incontinence and psychotropic medication use. Be sure the resident's call light was within reach and encourage the resident to use it for assistance as needed. The resident required an antidepressant.During an observation and interview on [DATE] at 9:28 a.m., Resident #5 was lying in bed watching TV. It was observed that the call light was hanging on the wall on the call light plug in plate, by the head of the bed. The resident did not respond to questions and did not acknowledge that the state surveyor was talking to him.During an interview on [DATE] at 9:30 a.m. with CNA L revealed Resident #5 was able to use his call light for assistance. She said Resident #5 was oriented to person, place, and situation, ambulatory with a walker, and he did not like to use his call light and hang the call light on the wall. She said the nursing staff had been trained to place the call lights within reach, and all staff were responsible for checking the call lights were always kept within reach.During an observation and interview on [DATE] at 9:47 a.m. the Administrator revealed resident #5's call light was hung on the wall plug in plate by the head of the bed. She said the nursing staff were trained to place the call lights within reach, and all staff were responsible for checking the call lights to ensure they were always kept within reach.4. Record review of Resident #8's admission Record dated [DATE] revealed an original admission date of [DATE] and re-admission date [DATE].Record review of Resident #8's History & Physical, dated [DATE], revealed a [AGE] year-old male with medical history of hypertensive heart disease (damage from long-term high blood pressure, forcing the heart to work harder, causing the muscles to thicken, weaken or stiffen, leading to problems like heart failure, or heart attack), OCD (a cycle where unwanted, intrusive thoughts (obsessions) cause intense anxiety, leading to repetitive actions, or mental rituals (compulsions) performed to temporarily reduce that anxiety or prevent a feared outcome), vascular dementia (when brain function declined because of blood flow to the brain was reduced, often from strokes or damage vessels, depriving brain cells of oxygen and nutrients, leading to problems with memory, thinking, planning and judgment, with symptoms appearing suddenly or gradually depending on the damage's location and severity), multiple cerebral infarcts (several areas of the brain died due to a blocked blood supply, causing small strokes), orthostatic hypotension (a sudden drop in blood pressure when the person stood up from sitting down, causing dizziness, lightheadedness, or fainting because blood flow to the brain temporarily decreased), repeated falls, oriented to person. Record review of Resident #8's Quarterly MDS, dated [DATE], revealed clear speech, usually makes self-understood, usually understand others, BIMS Summary Score 0 (cognitively severely impaired), inattention, disorganized thinking, independent with mobility, occasionally incontinent of urine and bowel, hypertension, CVA (a stroke, causing blood flow to part of the brain gets cut off, starving brain cells of oxygen and causing them to die), vascular dementia, and OCD.Record review of Resident #8's Care Plan, revised [DATE], revealed Resident #8 had bowel and bladder incontinence r/t impaired cognition. Resident #8 had a stroke. Resident #8 had impaired cognitive function r/t dementia and an ADL deficit. Encouraged the resident to use bell for assistance. Resident #8 had depression and mood problems. Resident #8 was at risk for falls r/t weakness and poor balance. Be sure the resident's call light was within reach and encourage the resident to use it. The resident used antipsychotic medications.During an observation and interview on [DATE] at 9:36 a.m., Resident #8 (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was lying in bed awake. It was observed that the call light was hung on the wall plug in plate by the head of the bed. Resident #8 was alert, oriented to person and place. The resident was able to answer simple questions. The resident did not answer when the state surveyor asked him if he could use his call light for assistance.During an observation and interview on [DATE] at 9:45 a.m., the Administrator revealed Resident #8's call light was hung on the wall plug in plate by the head of the bed. She said the nursing staff were trained to place the call lights within reach, and all staff were responsible for checking the call lights to ensure they were always kept within residents' reach.During an observation and interview on [DATE] at 10:00 a.m., CNA S revealed Resident #8 was oriented to person and place and used his call light at times for assistance. She said she checked for call light placement at the start of the shift. She said, Today I was late to work, and did not check for call light placement when I arrived at work. She said the nursing staff were trained to place the call lights within reach, and all staff were responsible for checking the call lights to ensure they were always kept within reach.During an interview on [DATE] at 10:07 a.m., LVN MDS Nurse M revealed Resident #8 was oriented to person, place and recognized familiar faces. He said Resident #8 used his call light at times for assistance.During an interview on [DATE] at 3:43 a.m. with the Administrator said, she was informed by the facility's corporate staff that they did not have a policy on call lights.5. Record review of Resident #7's admission Record dated [DATE] revealed an admission date of [DATE].Record review of Resident #7's History & Physical, dated [DATE], revealed a [AGE] year-old male with medical history of vascular dementia (when brain function declined because of blood flow to the brain was reduced, often from strokes or damage vessels, depriving brain cells of oxygen and nutrients, leading to problems with memory, thinking, planning and judgment, with symptoms appearing suddenly or gradually depending on the damage's location and severity), DM (a condition where the body has too much sugar in the blood because it does not make enough insulin or could not use it well), CVA with right hemiplegia (paralysis on one side, caused by CVA (a stroke, causing blood flow to part of the brain gets cut off, starving brain cells of oxygen and causing them to die)), pleasantly confused, and noncompliant with other medical treatment.Record review of Resident #7's Quarterly MDS, dated [DATE], revealed clear speech, usually makes self-understood, usually understand others, BIMS Score 11 (moderate cognitive impairment), moderate assistance with toileting, partial/moderate assistance with sit to stand, chair/bed transfer, and toilet transfer, occasionally incontinent of urine, DM, Non-Alzheimer's Dementia (losing the thinking, memory, and social skills enough to mess up daily life), CVA with right hemiplegia.Record review of Resident #7's Care Plan, revised [DATE], revealed Resident #7 had a communication deficit. Resident #7 was diabetic. Resident #7 had hemiplegia r/t CVA. Resident #7 had a contracture (a permanent tightening and stiffening of muscles, tendons, skin, or other soft tissue that restricts normal movement of a joint, often due to scarring, from injury, disuse, or nerve damage) of the right hand. Resident #7 preferred call light to be placed in bedside drawers. Resident #7 had impaired visual function. Resident #7 had an ADL Self-Care deficit r/t Hemiplegia. Resident #7 at risk of falls r/t balance problems, hemiplegia. Be sure the resident's call light was within reach and encourage the resident to use it. During an observation and interview on [DATE] at 9:54 a.m., revealed Resident #7 was lying in bed watching TV. He was oriented to person, and place. It was observed that the call light was hung on the wall plug in plate by the head of the bed. He said, I am able to walk and do not use the call light for assistance.During an observation and interview on [DATE] at 9:54 AM with LVN Charge Nurse D assigned to Resident #7 on the day shift revealed, resident was oriented to person and place, recognized familiar people. He said Resident #7 used his call light at times for assistance with toileting. Upon entering Resident #7's Room with (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LVN D it was observed that the call light was hung on the wall plug in plate by the head of the bed. LVN D placed the resident's call light within reach. He said the nursing staff were trained to place the call lights within reach, and all staff were responsible for checking the call lights to ensure they were always kept within residents' reach. He said he checked for call light placement at the start of the shift and randomly during rounds.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement written policies and procedures to prohibit and prevent abuse, neglect, and exploitation for 7 of 10 employees (DON, CNA P, SW B, LVN D, LVN N, CNA L and RN O) reviewed for employee misconduct registry and nurse aide registry screenings; the facility failed to complete Criminal Check for 2 (LVN N and RN O) of 10 employees reviewed for criminal checks. The facility had failed to have copies of previous annual employee misconduct registry and annual nurse aide registry screenings for DON, CNA P, LVN D, LVN N, CNA L and RN O in their personnel files. The facility failed to have a dated initial EMR/NAR check for Social Worker B upon hire on 09/18/25.The facility failed to complete the annual EMR/NAR screenings on LVN Charge Nurse on 01/09/26 according to facility's policy.The facility failed to complete a Criminal Check on LVN N and RN O upon hire.This failure could place residents at risk for abuse, neglect, exploitation, and misappropriation of property. Findings included:During an interview and record review on 01/09/26 at 4:30 p.m. with the HR Coordinator in the presence of the administrator, said she had started working at the facility on 09/18/25 and the Corporate HR Resource Manager had assisted her to compile the employees Criminal Checks and EMR/NAR selected for personnel file review with the state surveyor, revealed the following:RN Charge Nurse O revealed a rehire date of 02/23/24: Interview on 01/09/26 at 4:46 PM with the HR Coordinator revealed she had not found the Criminal Check report for RN O in her office and/or her personnel file, to show that the Criminal Check was completed upon rehire on 02/23/24. Record review of the most recent EMR/NAR check revealed it was completed on 01/20/25 by the previous HR Coordinator. The HR Coordinator said she had not found another EMR/NAR report in the RN O's employee records and/or personnel file to show the EMAR/NAR check was completed annually.CNA P DOH: 01/30/2020. Review of the most recent EMR/NAR check was completed on 02/19/25 by the previous HR Coordinator. Interview on 01/09/26 at 4:52 PM with the HR Coordinator said she had not found the previous EMR/NAR check in the employee's records and/or personnel file for CNA P to show it was completed annually.Social Worker B DOH: 09/18/25. Record review of the initial EMR/NAR revealed it was not dated. Interview on 01/09/26 at 4:59 PM, with the HR Coordinator said, The EMR/NAR report is not dated because Tulip was down when the check was completed. I can provide you with the copy of the email sent to the facility, letting us know that Tulip was down on that day. I did not run another EMR/NAR check once Tulip was working.LVN Charge Nurse D revealed Rehired Date: 09/09/2025. Review of the EMR/NAR was completed on 01/09/25 by the previous HR Coordinator. Interview on 01/09/26 at 5:00 PM with the HR Coordinator said she had not found the previous EMR/NAR check in LVN D's, employee record/personnel file to show the EMAR/NAR check was completed annually.Director of Nurses DOH: 02/26/24. Review of the EMR/NAR revealed it was completed on 01/21/25 by the previous HR Coordinator. Interview on 01/09/26 at 5:15 PM, with the HR Coordinator said she had not found the previous EMR/NAR check in the DON's employee's records and/or personnel file to show it was completed annually.LVN Charge Nurse N Rehire Date: 12/01/2023: Interview on 01/09/26 at 5:39 PM, with the HR Coordinator revealed she had not found the Criminal Check report for LVN N in her office and/or her personnel file, to show that the Criminal Check was completed upon rehire. Review of the last Annual EMR/NAR for LVN N revealed it was completed on 01/21/25 by the previous HR Coordinator. The HR Coordinator said she had not found another EMR/NAR report in the LVN N's employee's records and/or personnel file to show the EMAR/NAR check was completed annually.CNA L DOH: 11/22/24. Review of the most recent EMR/NAR check was completed on 02/19/25 by the previous HR Coordinator. Interview on 01/09/26 at 5:53 PM with the HR Coordinator said she had not found the previous EMR/NAR check in the CNA L's employee records and/or personnel file to show it (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was completed annually.Record review of facility's policy on Abuse/Neglect revised 03/29/18 revealed that the resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. Procedure A. Screening: Criminal History and Background Checks. The facility will conduct criminal background checks of all personnel in accordance with Texas Health and Safety Code, Chapter 250. The facility administrator will be responsible for ensuring compliance with the policy and Texas state law regarding criminal background checks. All potential employees will be screened for history of abuse, neglect or mistreating of elderly. The Human Resource Clerk will monitor completeness and status of the criminal history checks for the facility. A copy of the completed tracking form will be maintained in the facility file. Employees will be screened for abuse, neglect, and exploitation of the elderly by accessing the Employee Misconduct Registry by calling the Texas Department of Aging and Disability at [PHONE NUMBER]. The hiring authority is responsible for training an individual to complete misconduct registry checks on every employee.Record review of the facility's HR - Personnel Handbook dated 2019, provided by facility's administrator revealed, Employment Eligibility - All employment applicants must go through an eligibility screening process prior to being hired. This process includes the Office of Inspector General, Misconduct/Nurse Aide Registry, Company-Wide Do Not Hire List, Criminal History Database, and any licensure board associated with your credentialing requirements. This facility completes a comprehensive background check prior to offer of employment, annually following your hire and as needed for reported concerns that could impact the resident care or facility liability. I any of the above-mentioned database are not operational: the facility will follow the directive or recommendations by the respective authority for a resource to obtain the employability validation.

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	01/09/2026

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 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Hire a qualified full-time social worker in a facility with more than 120 beds. Based on interview and record review the facility failed to ensure that it employed a qualified social worker on a full-time basis for one of one social worker positions reviewed for social services. The facility, which was licensed for 132 beds, failed to employ a qualified social worker on a full-time basis since 08/05/2025. This failure could place residents at risk of not having their psychosocial or discharge planning needs met. Findings included:During an interview and record review on 01/09/26 at 4:59 p.m., with the facility's administrator in the presence of the HR Coordinator, Social Worker B revealed that he was hired on 09/18/25. The administrator said, Social Worker B does not have a license and was scheduled to take his test on 01/30/25. The administrator said the previous Social Worker's last day of work was on 08/05/25.Record review of the Social Worker Job Description, signed by Social Worker B on 09/18/25, provided by the facility's administrator, revealed the following was non-exhaustive criteria related to the job of a Social Worker, and it was consistent with the business needs of the facility. These are legitimate measures of qualifications for a Social Worker and are related to the functions that are essential to the job of a Social Worker. Knowledge Base: A bachelor's degree in social work, or secondary education in social services and certification as a social worker designee may be substituted as appropriate. Long Term Care experience. Develops social histories of residents and develops a social assessment and care plan for each resident which identifies medically related social and emotional problems and needs.