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	03/27/2026

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 - Few	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 had 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 for 1 of 6 residents (Resident #2) reviewed for call light placement. The facility failed to ensure call lights were in reach for Resident #2 on 03/27/2026. This failure could place residents by not having access to call for assistance resulting in needs not being met.Findings include:Record review of Resident #2's face sheet, dated 03/27/2026, revealed a [AGE] year-old male with an admission date of 02/05/2022. Record review of Resident #2's history and physical, dated 11/15/2025, revealed a [AGE] year-old male with diagnoses which included hypertension (high blood pressure), dementia (a decline in memory and thinking abilities affecting daily life), COPD (a chronic lung disease that makes it difficult to breathe),, coronary artery disease (narrowing of the arteries that supply blood to the heart), chronic kidney disease (long-term damage to the kidneys affecting their function), and history of falls.Record review of Resident #2's annual MDS, dated [DATE], revealed a BIMS score of 0, which indicated severe cognitive impairment, meaning the resident was unable to recall information or effectively participate in the interview. Section GG, Functional Abilities and Goals, documented Resident #2 required substantial/maximal assistance with toileting hygiene (needed extensive help with cleaning self after using the restroom), upper body dressing (needed help putting on or removing clothing above the waist), lower body dressing (needed help putting on or removing clothing below the waist), and transfers (needed significant help moving from one surface to another such as bed to chair).Record review of Resident #2's care plan, dated 03/20/2026, revealed interventions directing staff to ensure the call light was within reach and to instruct the resident to use the call light for assistance as needed.During an observation and interview on 03/27/2026 at 11:31 a.m. in Resident #2's room, revealed the resident was lying in bed, and his call light was on the floor towards his feet. Resident #2 was confused and was talking and saying words, but it was uncomprehensible. Resident #2 had his bed sheet on his hand and the only discernible words he talked in Spanish were cold during the night.During an interview on 03/27/2026 at 11:30 a.m., CNA A stated call lights needed to always be within the resident's reach so residents could request assistance if needed. CNA A stated all staff who worked directly with residents such CNAs, LVNs and RNs were responsible for checking all residents who were in their rooms, had their call lights within reach. CNA A stated if a resident did not have their call light within reach it could result in them not having access to services in a timely manner or that they could not ask for help when they needed assistance to transfer or toileting.During an interview on 03/27/2026 at 11:34 a.m., CNA B stated call lights needed to be within the residents reach when they were in their room so they could ask for help or assistance whenever they needed it. CNA B stated not having access to their call lights, residents could potentially try to get up on their own and fall to the floor which could result in injuries.During an interview on 03/27/2026 at 11:37 a.m., LVN C stated call lights needed to always be within the resident's reach while they were in their room. He stated by not having a call light within reach, the potential outcome could be that the residents did not receive assistance in a timely manner or if there (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
	675479	A. Building B. Wing	03/27/2026

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 - Few	was an emergency such as a fall, they would not be able to call for help for them to be assessed, creating delays in care for the residents.During an interview on 03/27/2026 at 11:49 a.m. with LVN D, she stated call lights needed to be close to the resident and within reach. LVN D stated all staff were responsible for checking and monitoring to ensure residents had their call lights within reach while they were in their rooms. LVN D stated if the residents did not have their call light within reach, it could potentially place residents at risk if they tried to get up to get help, they could potentially fall to the floor causing injuries. LVN D stated there could potentially be delays in care if the call light is not within reach and they couldn't ask for help or assistance from the staff.During an interview on 03/27/2026 at 1:25 p.m. with the DON, she stated the facility did not have policies and procedures for call lights. The DON stated call lights had to be within reach of the resident so the resident could call for assistance whenever they needed help or assistance. The DON stated if residents couldn't reach the call light, there was a potential to delayed care for the resident's treatment in a timely manner. The DON stated residents with balance issues and confusion could potentially try to get up on their own and fall to the floor which could result in injuries or hospitalization.During an interview on 03/27/2026 at 1:53 p.m. with the Administrator, she stated all RNs, LVNs and CNAs were primarily responsible for checking that residents had their call lights within reach. The Administrator stated the potential negative outcome for a resident not having their call light within reach, could result in the residents not being able to call staff for assistance which could delay treatment or addressing emergencies such as falls or helping to manage pain.Record review of an email received on 03/27/2026 at 12:21 p.m. Sent by the DON, the DON stated the facility did not have a policy on call lights.

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	03/27/2026

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that a resident who needed respiratory care was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident goals and preferences for 1 of 6 residents (Resident #1) reviewed for oxygen management. The facility failed to post an Oxygen sign that documented Resident # 1 received oxygen in her room on 03/27/2026. This failure could place residents at risk of receiving incorrect or inadequate oxygen support and decline in health and risk of fire hazards.Findings include: Record review of Resident #1's face sheet, dated 03/27/2026, revealed an [AGE] year-old female with an admission date of 07/21/2018.Record review of Resident #1's history and physical, dated 10/30/2025, revealed an [AGE] year-old female with diagnoses which included Alzheimer's disease (a progressive brain disorder that affects memory, thinking, and behavior), chronic obstructive pulmonary disease (COPD) (a chronic lung disease that makes it difficult to breathe), allergic rhinitis (inflammation of the nasal passages caused by allergies), and dementia (a decline in memory and cognitive function affecting daily life).Record review of Resident #1's annual assessment MDS ,dated 01/05/2026, revealed a BIMS score of 0, which indicated severe cognitive impairment. Section I Active Diagnoses, included Asthma (a condition where airways in the lungs become inflamed, narrow and sensitive making It harder to breathe), COPD, or Chronic Lung Disease.Record review of Resident #1's care plan, dated 01/13/2026, revealed interventions related to oxygen therapy, which included oxygen administration at 2 liters per minute via nasal cannula as needed for oxygen saturation at or below 90 percent, monitoring of respiratory status, and interventions to support adequate oxygenation. During an observation on 03/27/2026 at 11:29 a.m. in Resident #1's room revealed the resident was asleep in bed. She was wearing her nasal cannula, and her oxygen concentrator was turned on. There was no oxygen sign posted outside Resident #1's room. During an interview on 03/27/2026 at 11:28 a.m., CNA A stated an oxygen sign needed to be posted outside every room that had an oxygen concentrator inside. CNA A stated the potential negative outcome for a resident who had an oxygen concentrator inside their room and had no sign posted, could result in staff not monitoring the oxygen levels for a resident and not provide the necessary services for oxygen. CNA A stated there was a fire hazard if a resident or visitor went inside a room with a concentrator and if they had a lighter and they used it, it could potentially cause a fire in the room. During an interview on 03/27/2026 at 11:33 a.m., CNA B said the oxygen sign needed to be posted outside the room if the resident had an oxygen concentrator in the room regardless if they were using it or not and said the potential negative outcome could be a fire accident or the resident was not monitored for oxygen levels and care. During an interview on 03/27/2026 at 11:35 a.m. with LVN C, he stated oxygen signs always needed to be posted outside the door if there was a concentrator in the room. LVN C stated the potential negative outcome for not posting an oxygen sign outside a residents' room could result in the resident not being checked for oxygen levels and a potential for a fire hazard if someone who didn't know there was oxygen in use in the room brought in a lighter or something that could create a spark causing a fire. During an interview on 03/27/2026 at 11:48 a.m. with LVN D, she stated oxygen signs needed to be posted outside the residents' room so the staff were aware the residents received oxygen and said by not having an oxygen sign posted, staff could miss the room and miss to check for oxygen levels on the resident. LVN D stated there was also a fire hazard if a visitor went into the room with a lighter and they're not aware of there being oxygen in use. During an interview on 03/27/2026 at 12:59 p.m. with the SW, he stated the facility needed to have oxygen signs posted outside of the room of all residents who had oxygen therapy. The SW stated the potential negative outcome for not posting an oxygen sign could result in staff not checking the oxygen concentrators to make sure they were clean or to check if they needed water. The SW stated there was also potential for fire hazards if a visitor or a confused resident got (continued on next page)

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	03/27/2026

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ahold of a lighter and they initiated a spark; there could be a fire in the room affecting the resident and the roommate. During an interview on 03/27/2026 at 1:22 p.m. with the DON, she stated there should be an oxygen sign posted outside the room if there was oxygen in use in the room to make residents and visitors aware. The DON stated by not having an oxygen sign posted outside the room, staff or visitors would not know there's oxygen use in the room and they could not have the extra caution by making sure they did not create sparks with things like lighters, or the facility staff overlooked the room and did not check for oxygen levels for those residents who were in oxygen therapy, affecting their health. During an interview on 03/27/2026 at 1:49 p.m. with the Administrator, she stated oxygen signs needed to be posted outside of any room that had an oxygen concentrator. The Administrator said the purpose of an oxygen sign was to inform nursing staff the resident in the room had oxygen so they could follow up and check on oxygen levels according to the residents' care plan. The Administrator stated by not posting an oxygen sign outside the resident's room, it could delay supervision for residents who received oxygen. The Administrator stated there was a potential for fire hazards if a visitor went into the room and had a lighter and if they created a spark, it could catch fire harming the residents in the room. Record review of the facility's, undated, policies and procedures titled Oxygen Administration, read in part: Oxygen therapy includes the administration of oxygen (O2) in liters/minute (l/min) by cannula or facemask to treat hypoxemic conditions caused by pulmonary or cardiac diseases. O2 therapy is alsoprescribed to ensure oxygenation of all body organs and systems. The amount of oxygen by percent ofconcentration or L/min, and the method of administration, is ordered by the physician. Theadministration, monitoring of responses, and safety precautions associated with it are performed by thenurse. The nasal cannula delivers 22-40 % oxygen and is the most common, inexpensive, and easiestdevice to use. Common oxygen sources for long-term administration include cylinder (portable orstationary) or wall system near the resident's bed or concentrator. Procedure 11. Place NO SMOKING signs in area when oxygen is administered and stored. Store oxygen cannister in an area free of flammable substances. Avoid the use of electrical appliances in the area of oxygen use as well. If the facility is non-smoking, oxygen in use signs are not required on individual resident rooms.