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	05/31/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34486 49850 Based on observations, interviews, and record review the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life, recognizing each resident ' s individuality for 4 (Resident #16, #54, #58, and #89) of 10 reviewed for dignity and 2 (the DON and CNA A) of 7 staff reviewed for Resident dignity. The facility failed to ensure staff were not standing up and feeding the residents in the main dining room. The facility failed to ensure that Resident #54 was offered a clothing protector resulting in his clothing being soiled during meals. The facility failed to ensure that Resident #58's privacy was respected by not covering his Foley bag with a privacy bag. The facility failed to provide personal hygiene for Resident #89 by not removing her facial hair. These failures could result in residents having decreased self-esteem and sense of worth. Findings included: Resident #16 Review of Resident #16 ' s face sheet dated 05/29/24, revealed admission on 06/10/22 and re-admission on 01/11/24 to the facility. Review of Resident #16 ' s facility history and physical dated 06/01/23, revealed an [AGE] year-old male diagnosed with Diabetes Mellitus, Dementia, and Cardiovascular Accident (a brain attack, is an interruption in the flow of blood to cells in the brain). (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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	675479	A. Building B. Wing	05/31/2024

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #16 ' s quarterly MDS dated [DATE], revealed BIMS (A brief interview for mental status) score of 4 (severely impaired cognition). Eating-required setup and/or cleanup assistance from staff. Record review of Resident #16 ' s care plan dated 07/12/22, required 1 person participation to eat. Observation on 05/07/24 at 12:28 PM revealed CNA A was standing up assisting with feeding residents in the main dining room. It was observed that the Director of Area Operations grabbed a stool and pushed it over to CNA A, behind her knees, and told her to sit down. Observation on 05/07/24 at 12:59 PM revealed Resident #16 was seen at his table sitting down in his wheelchair. The DON was standing next to him and was assisting him with feeding. It was observed that the Director of Area Operations grabbed a chair and took it to the DON so that she could sit down to feed the resident. During an interview on 05/30/24 at 11:22 AM, with LVN B, she reported the staff needed to sit down when feeding a resident. LVN B stated eye contact had to be made and the staff needed to be close to the resident to monitor their swallowing or a change. LVN B stated those details cannot be observed if the staff are standing up. LVN B stated the negative outcome could be the resident pocketing food, choking, or they could aspirate. During an interview on 05/31/24 at 1:13 PM, with the DON, revealed she consistently tells the staff to sit down when helping with feeding a resident. The DON stated that feeding residents standing up was a dignity issue. Resident #54 Record review of Resident #54 ' s face sheet dated 05/31/2024 revealed he was [AGE] years old, initially admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #54 ' s history and physical dated 12/28/2023 revealed he had diagnoses including [NAME] ' s encephalopathy (brain damage), liver disease, and vascular dementia (brain damage from strokes). Record review of Resident #54 ' s quarterly MDS assessment dated [DATE] revealed he had short- and long-term memory problems. His cognitive skills for daily decision making were severely impaired. He required supervision during eating to use suitable utensils to bring food to his mouth once the meal was placed before him. He received a mechanically altered diet (chopped or pureed). Record review of Resident #54 ' s Care Plan dated 05/28/2024 revealed that he ate with his hands and would eat the dietary paper slip on his tray. Observation and interview on 05/28/24 at 01:06 PM revealed Resident #54 was eating lunch in the main dining room with his hands and had food particles on his shirt and pants. The resident was not able to answer simple questions. The resident did not have a clothing protector while he was eating. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 05/29/24 at 01:25 PM revealed Resident #54 was seated in the dining room eating. He was holding a bowl of creamy soup in his hands and was eating the soup by scooping it up with his fingers and bringing it to his mouth. Soup was observed spilling down the front of his shirt and onto his pants. The resident did not have a clothing protector on while he was eating. Observation and interview on 05/31/2024 at 8:37 AM revealed Resident #54 was seated in the dining room eating. He was holding a bowl of thin oatmeal in his hands and was eating the oatmeal by scooping it up with his fingers and bringing it to his mouth. The oatmeal was observed spilling down the front of his shirt and onto his pants. He said the oatmeal was good but was not able to respond to other questions. The resident did not have a clothing protector on while he was eating. In an interview on 05/31/24 at 9:10 AM with LVN C revealed that Resident #54 always ate with his hands. He said that the CNAs offered a clothing protector to the resident, but he would take it off. The LVN stated he did not know if the CNAs had offered a clothing protector to Resident #54 that morning. He said if he were Resident #54, he would feel bad having oatmeal on his clothing, and that eating with his hands could put the resident at risk of infection. In an interview on 05/31/24 at 09:46 AM LVN F revealed CNAs should offer Resident #54 a clothing protector when eating. She said that Resident #54 would sometime refuse to use one but that the CNAs should offer one anyway. She said she would be embarrassed if she had food down the front of her clothing. She said that eating with his hands could put him at increased risk of infection. In an interview on 05/31/24 at 9:15 AM, CNA H revealed that the CNAs decided which residents needed a clothing protector. She stated when she did offer Resident #54 a clothing protector, he would just take it off. She said she should offer to help him eat but he would refuse her help. In an interview on 05/31/24 at 9:21 AM CNA I revealed that she decided who needed a clothing protector based on who was a messy eater. She stated the morning of 05/31/2024 she did not offer Resident # 54 a clothing protector because she got too busy and did not think about it. She said Resident #54 would grab the whole plate and eat with his hands. She said that in the past when she offered him a clothing protector, she would have to be putting it back on him constantly. She said that eventually she would stop putting it on him and leave the used clothing protector on the table. She said she would not want to have food down the front of her because she would be embarrassed. In an interview on 05/31/24 at 01:43 PM, the DON revealed that the floor nurse or CNA would offer residents clothing protectors to keep the resident and resident ' s clothing clean. She said that the use of clothing protectors helped maintain resident ' s dignity and was important for resident safety in case the food was too hot. She stated that CNAs do not offer clothing protectors to all residents but only to those who require them because of difficulty eating. The DON stated that not having a clothing protector could put Resident #54 at risk of a decreased sense of dignity. She said that refusal of clothing protectors should be on Resident #54 ' s care plan. Resident #58 Record Review of Resident #58 ' s Face Sheet dated 05/31/2024 revealed he was [AGE] years old, admitted to the facility on [DATE]. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #58 ' s history and physical dated 11/15/2023 revealed he had diagnoses of hypertension, type 2 diabetes mellitus, depression, and schizophrenia. Resident #58 had social issues of being homeless and unable to take care of himself. He also had a psychiatric medical history, not being compliant with medications, or plan of care. Resident #58 required nursing care around-the-clock. Record review of Resident #58 ' s quarterly MDS dated [DATE], revealed a BIMS score of 15 indicating he was cognitively intact. Record review of Resident #58 ' s care plan dated 08/02/2023, revealed Resident #58 has a Benign Prostatic Hypertrophy (a condition in men where the prostate gland enlarges and as the prostate grows, it can press against the urethra and bladder, which can make or difficult or impossible for urine to flow) and was at risk of urinary retention. The care plan also revealed that Resident #58 had an indwelling catheter r/t obstructive uropathy (a disorder of the urinary tract that occurs due to obstructed urinary flow). The care plan instructed to position the catheter bag and tubing below the level of the bladder and in a privacy bag. Observation on 05/29/24 at 01:24 PM revealed Resident #58 was lying in bed and his catheter bag was not covered by a privacy bag and it was hanging from the trash can near the floor. The catheter bag was not placed inside a dignity bag. In an interview with Resident #58 on 05/29/24 at 01:24 PM, revealed he did not know why the bag was not in the blue bag. Resident #58 said that when he sat on his wheelchair, the urine bag was covered with a blue bag but that he did not know why it was not covered when he was lying down on his bed. Observation on 05/31/24 at 8:59 AM revealed that Resident #58 was sleeping in his bed and the catheter bag was hanging from the resident's side bed rail and was not in a dignity bag. In an interview on 05/31/24 at 10:10 AM with LVN E revealed that catheter bags must be placed in a dignity bag for privacy, even if the resident was in his room alone. She said that if the bag was not placed in a dignity bag it could create embarrassment for the resident because it violated his privacy. Upon observation of the picture taken on 05/29/24 at 1:24 PM, LVN E stated that it was not acceptable for the bag to be uncovered and hanging from the trash can. She said that there was a risk of infection for the bag being hanging from the trash can. In an interview on 05/31/24 at 10:23 AM with LVN B revealed that the foley bag needed to be placed in a dignity bag, no matter if the resident was by himself in his room or if he was out in the common areas. Upon observing the picture taken on 05/29/24 at 1:24 PM, LVN B stated that the bag was not covered and that it shouldn't be hanging from a trash can due to the risk of infections or contamination. In an interview on 05/31/24 at 11:50 AM with the DON revealed the catheter bag should be placed in a dignity bag to respect the resident ' s dignity. The DON stated that it was expected for licensed staff to make rounds throughout their shifts to check on the Residents assigned to their halls for any privacy issues. The DON said that by the bag not being covered, it could result in Resident #58 feeling embarrassed since he was very vocal, and his cognitive level was high. (continued on next page)

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	675479	A. Building B. Wing	05/31/2024

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Franklin Heights Nursing & Rehabilitation	223 S Resler El Paso, TX 79912

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #89 Record Review of Resident #89 ' s Face Sheet dated 05/30/2024 revealed she was [AGE] year-old female, admitted to the facility on [DATE]. Record review of Resident #89 ' s history and physical dated 03/18/2024 revealed she had a diagnosis of dementia. Record review of Resident #89 ' s quarterly MDS dated [DATE], revealed a BIMS score of 3 (severely impaired cognition). Record review of Resident #89 ' s care plan dated 04/16/2024, revealed ADL self-care performance unable to perform the routine task required to care for herself independently. Intervention: needs assistance with personal hygiene shaving as needed. Observation on 05/29/2024 at 10:52 AM revealed Resident #89 was sitting in the hallway sitting in her wheelchair. It was observed that she had facial hair about 3 cm long on her chin. Observation on 05/30/2024 at 02:24 PM revealed Resident #89 was sitting in the hallway sitting in her wheelchair. It was observed that she had facial hair about 3 cm long on her chin. In an interview with Resident #89 on 05/31/2024 at 09:10 AM revealed she felt embarrassed that she has facial hair. Resident #89 stated she has only been asked several times by the CNAs if she wants to be shaved and cannot recall the last time they had asked her. A telephone call was placed on 05/31/24 at 11:20 AM to Residents #89's daughter who was her Responsible Party. She did not answer so a voicemail was left. The Responsible Party did not return telephone call, prior to exiting the facility. In an interview on 05/31/2024 at 11:31 AM with the ADON, it revealed staff had been trained to ask the residents if they want shave during their showers. If there was any resistance to shaving, then it needed to be brought up to the family. She stated depending on what was agreed on it would need to be care planned. As a reasonable person concept, the ADON stated she would not want to have facial hair. It needed to be removed if the resident allowed it. She stated that Resident #89 resisted care. The ADON stated Resident had not voiced any concerns about the facial hair. Interview and record review on 05/31/2024 at 01:57 PM with the Administrator stated the facility does not have a specific policy regarding shaving female resident ' s facial hair but does have a Grooming Activities policy. The policy did not state anything about shaving female residents. In an interview on 05/31/24 at 02:23 PM LVN L stated that Resident #89 did refuse ADL care at times. She stated CNAs should shave a resident when they were showered. As a reasonable person concept, LVN L stated she would not like it if she had facial hair. Record review of the facility ' s Resident Rights policy dated 11/28/16 revealed, Respect & Dignity - The resident has a right to be treated with respect and dignity. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility Feeding, Assistive/Complete policy dated 02/14/07, revealed, assist with feeding as needed - Place the napkin or small towel over the chest or tuck under the chin. Staff should position themselves so not to stand over the resident while assisting with the meal.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 46998 Based on interviews and record review the facility failed to implement written policies that prohibit and prevent abuse for misappropriation of property for 1 (alleged allegation of unknown resident) of 1 alleged allegation reviewed for abuse. The facility failed to implement their abuse policy when they failed to report, investigate, and protect residents from further potential abuse when it was reported on 05/30/24 to the DON by LVN D that LVN K was stealing resident (unknown who the resident(s) were) medications. This placed residents at risk for misappropriation of property and other abuses by not immediately following the facility abuse policy and procedure manual of recognizing, reporting, investigating, and allegations of misappropriation and other abuses. Finding included: During an interview on 05/30/24 at 2:32 PM, with the DON, revealed she had received a report from LVN D. The DON stated LVN D made malicious allegations about other nurses. The DON stated LVN D made a malicious report regarding LVN K taking medications from the residents. The DON stated she followed up with LVN K and no one had reported any missing medications. The DON stated she had just started her investigation. The DON stated she did not report it to the Administrator. The DON stated as per the facility policy and protocol it had to be reported to the state agency, which was not reported too. During an interview on 05/30/24 at 3:15 PM, with the Administrator, Regional Compliance Nurse, and the DON. The Regional Compliance Nurse stated during a conversation with the DON on 05/30/24, the DON had reported to her that LVN D had told her that LVN K was stealing medications from the residents. The Administrator stated she was unaware of the situation. The DON stated she should have immediately reported it to the Administrator. The Administrator and Regional Compliance Nurse stated it should have been reported to the state agency when the facility received the allegation. Record review of the facility Abuse/Neglect policy dated 03/29/18, revealed, The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. It was each individual ' s responsibility to recognize, report, and promptly investigate actual or alleged abuse, neglect, exploitation, mistreatment of residents, or misappropriation of resident property abuse and situations that may constitute abuse or neglect to any resident in the facility. Misappropriation of Resident Property: the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident ' s belongings or money without the resident ' s consent. Reporting - Any person having reasonable cause to believe an elderly or incapacitated adult was suffering from abuse, neglect, or exploitation must report this to the DON, Administrator, state and or adult protective services. State law mandates that citizens report all suspected cases of abuse, neglect, or financial exploitation of the elderly and incapacitated persons. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility employees must report all allegations of abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident properly or injury of unknown source to the facility administrator. The facility administrator or designee will report to HHSC all incidents that meet criteria of Provider Letter 19-17 dated 07/10/19. Record review of facility Long Term Care Regulatory Provider Letter dated 07/10/19, revealed, A Nursing facility must report to HHSC the following types of incidents, in accordance with applicable state and federal requirements: Abuse, Neglect, Exploitation, Misappropriation, Drug Theft, Death due to unusual circumstances, Fire, Emergency situations that pose a threat to resident health and safety. State and federal law requires an owner or employee of nursing facility who has cause to believe that the physical or mental health or welfare of a resident has been or may be adversely affected by abuse, neglect, or exploitation caused by another person to report the abuse, neglect, or exploitation. Nursing facility must report all suspected or alleged incidents involving abuse, neglect, exploitation, or mistreatment of resident property. A Nursing facility must report these incidents to the HHSC CII section.

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	675479	A. Building B. Wing	05/31/2024

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 46998 Based on interviews and record review the facility failed to ensure alleged violations involving abuse, neglect, exploitation, or mistreatment, including misappropriation were reported immediately, but not later than 2 hours after the allegation was made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility, and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 1 (DON) of 1 DON reviewed for reporting. The DON was reported on 05/30/24 to by LVN D that an unknown nurse was stealing medications from an unknown resident(s) and failed to report it to the administrator which was not reported to the state agency. This failure could place all residents at risk for misappropriation of property by not immediately reporting allegations of misappropriation of property to the proper authorities at the facility, other officials, and state survey agency. Findings included: During an interview on 05/30/24 at 2:32 PM, with the DON, she stated she had received a report from LVN D. The DON stated LVN D tends to make malicious allegations towards other nurses. The DON stated LVN D made a malicious report to her on 05/28/24, regarding LVN K taking medications from the residents. The DON stated she did not report it to the Administrator. The DON stated as per the facility policy and protocol it had to report it to the state agency, which was not reported too. During an interview on 05/30/24 at 3:15 PM, with the Administrator, Regional Compliance Nurse, and the DON. The Regional Nurse stated during a conversation with the DON on 05/30/24, the DON had reported to her that LVN D had told her that LVN K was stealing medications from the residents. The Administrator stated she was unaware of the situation. The Administrator and Regional Compliance Nurse stated it should have been reported to the state agency immediately when the facility received the allegation. Record review of the facility Abuse/Neglect policy dated 03/29/18, revealed, The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. It was each individual ' s responsibility to recognize, report, and promptly investigate actual or alleged abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property abuse and situations that may constitute abuse or neglect to any resident in the facility. Misappropriation of Resident Property: the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident ' s belongings or money without the resident ' s consent. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reporting - Any person having reasonable cause to believe an elderly or incapacitated adult was suffering from abuse, neglect, or exploitation must report this to the DON, Administrator, state and or adult protective services. State law mandates that citizens report all suspected cases of abuse, neglect, or financial exploitation of the elderly and incapacitated persons. Facility employees must report all allegations of abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident properly or injury of unknown source to the facility administrator. The facility administrator or designee will report to HHSC all incidents that meet criteria of Provider Letter 19-17 dated 07/10/19. Record review of facility Long Term Care Regulatory Provider Letter dated 07/10/19, revealed, A Nursing facility must report to HHSC the following types of incidents, in accordance with applicable state and federal requirements: Abuse, Neglect, Exploitation, Misappropriation, Drug Theft, Death due to unusual circumstances, Fire, Emergency situations that pose a threat to resident health and safety. State and federal law requires an owner or employee of nursing facility who has cause to believe that the physical or mental health or welfare of a resident has been or may be adversely affected by abuse, neglect, or exploitation caused by another person to report the abuse, neglect or exploitation. Nursing facility must report all suspected or alleged incidents involving abuse, neglect, exploitation or mistreatment of resident property. A Nursing facility must report these incidents to the HHSC CII section.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 46998 Based on interviews, and record review the facility failed to ensure violations were thoroughly investigated with results of the investigations presented to the administrator and to other officials in accordance with state law including to state survey agency, within 5 working days of the incident and if the alleged violation was verified appropriate corrective action must be taken for 1 (stealing of medications) of 1 facility medication reviewed for incidents. The facility failed to thoroughly investigate the stealing of medications reported on 05/30/24 to the DON. This failure could place residents at risk for abuse, neglect, exploitation, and misappropriation of property and decreased quality of life. Findings included: During an interview on 05/30/24 at 2:32 PM, with the DON, she stated she had received a report from LVN D. The DON stated LVN D tenses to makes malicious allegation towards other nurses. The DON stated LVN D made a malicious report to her on 05/28/24, regarding LVN K taking medications from the residents. The DON stated she followed up with LVN K and no one had reported any missing medications. The DON stated she had just started her investigation on 5/30/24. During an interview on 05/30/24 at 3:15 PM, with the Administrator, Regional Compliance Nurse, and the DON. The Regional Nurse stated during a conversation with the DON on 05/30/24, the DON had reported to her that LVN D had told her that LVN K was stealing medications from the residents. The Administrator stated she was unaware of the situation. The Administrator and Regional Compliance Nurse stated it should have been reported to the state agency when the facility received the allegation. Record review of the facility Abuse/Neglect policy dated 03/29/18, revealed, The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. It was each individual ' s responsibility to recognize, report, and promptly investigate actual or alleged abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property abuse and situations that may constitute abuse or neglect to any resident in the facility. Misappropriation of Resident Property: the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident ' s belongings or money without the resident ' s consent. Reporting - Any person having reasonable cause to believe an elderly or incapacitated adult was suffering from abuse, neglect, or exploitation must report this to the DON, Administrator, state and or adult protective services. State law mandates that citizens report all suspected cases of abuse, neglect, or financial exploitation of the elderly and incapacitated persons. (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	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Franklin Heights Nursing & Rehabilitation	223 S Resler El Paso, TX 79912

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility employees must report all allegations of abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident properly or injury of unknown source to the facility administrator. The facility administrator or designee will report to HHSC all incidents that meet criteria of Provider Letter 19-17 dated 07/10/19. Record review of the facility Event Reporting: Completion of policy and procedure not dated revealed, Investigation: The investigation should be completed by the DON/Administrator or designee. The investigation report documents a thorough investigation of the events including person, equipment, and materials involved. The investigation report must include what actions were taken to prevent subsequent events and signatures of the individuals as indicated on the form. Record review of facility Long Term Care Regulatory Provider Letter dated 07/10/19, revealed, A Nursing facility must report to HHSC the following types of incidents, in accordance with applicable state and federal requirements: Abuse, Neglect, Exploitation, Misappropriation, Drug Theft, Death due to unusual circumstances, Fire, Emergency situations that pose a threat to resident health and safety. State and federal law requires an owner or employee of nursing facility who has cause to believe that the physical or mental health or welfare of a resident has been or may be adversely affected by abuse, neglect, or exploitation caused by another person to report the abuse, neglect or exploitation. Nursing facility must report all suspected or alleged incidents involving abuse, neglect, exploitation or mistreatment of resident property. A Nursing facility must report these incidents to the HHSC CII section.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46998 Based on observations, interviews, and record review the facility failed to ensure that resident assessments were accurate for 3 (Resident #88, Resident #196, and Resident #198) of 5 residents reviewed for accuracy of resident assessments. The facility failed to accurately identify the need for oxygen therapy for Resident #88 admission MDS dated [DATE] and Resident #196 ' s admission MDS dated [DATE]. The facility failed to accurately identify the need for intervenors therapy for Resident #198 ' s admission MDS dated [DATE]. This deficient practice could place residents at risk of not receiving a completed initial assessment which could result in necessary care and services based on their individually assessed needs. Findings included: Resident #88 Record review of Resident #88 ' s face sheet dated 05/29/24, revealed admission on 03/22/24 and re-admission on 04/30/24 to the facility. Record review of Resident #88 ' s facility history and physical dated 03/22/24, revealed a [AGE] year-old male diagnosed with tongue and thyroid cancer and alcohol cirrhosis. Record review of Resident #88 ' s admission MDS dated [DATE], revealed a severely impaired cognition to be able to recall or make daily decision with a BIMS (tool used to screen and identify the cognitive condition of residents upon admission into a long-term care facility) score of 5. Resident #88 was diagnosed with cancer, muscle weakness (no muscle strength), and adult failure to thrive. Does not include that Resident #88 has trouble with shortness of breath. The MDS was not marked for oxygen therapy. Record review of Resident #88 ' s order recap dated 05/01/24, revealed oxygen via nasal cannula at 2 liters per minute via nasal cannula continuously every shift. Record review of Resident # ' s care plan dated 05/13/24, revealed oxygen therapy related to shortness of breath. Oxygen at blank (the amount of oxygen was not added and left blank) liters per minute per nasal cannula. Observation on 05/28/24 at 8:18 PM, the oxygen concentrator was running in Resident #88 ' s room and could be heard outside in the hallway. No Oxygen Sign was put up outside of Resident #88 ' s room. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 05/28/24 at 8:39 AM, Resident #88 was sitting down on her wheelchair eating breakfast. Resident #88 was wearing a nasal cannula with the concentrator on. Resident #88 stated she was on oxygen and needed it to breathe. Resident #196 Record review of Resident #196 ' s face sheet dated 05/29/24, revealed admission on 05/23/24 to the facility. Resident #196 was a [AGE] year-old female diagnosed with acute respiratory failure with hypoxia (a condition where you don ' t have enough oxygen in the tissues in your body). Record review of Resident #196 ' s admission MDS dated [DATE], revealed an intact cognition to be able to recall or make daily decisions with a BIMS (tool used to screen and identify the cognitive condition of residents upon admission into a long-term care facility) score of 15. Resident #196 was diagnosed with respiratory failure. Shortness of breath and oxygen therapy were not marked on the MDS. Record review of Resident #196 ' s order recap dated 05/23/24, revealed may use oxygen at 2 liters per minute via nasal cannula for oxygen saturations greater than 90 percent. May attempt to wean off oxygen every shift. Record review of Resident #196 ' s care plan dated 05/24/24, revealed oxygen therapy. Oxygen at blank (it was left blank) liters per minute per nasal cannula. Resident #196 has shortness of breath. Notify the charge nurse if the resident was having trouble breathing. Observation on 05/28/24 at 8:17 AM, the oxygen concentrator was running in Resident #196 ' s room and could be heard outside in the hallway. No Oxygen Sign was put up outside of Resident #196 ' s room. During an interview on 05/28/24 at 8:37 AM, with Resident #196, he stated he was on oxygen and had to use it. Resident # 198 Record review of Resident #198 ' s face sheet dated 05/29/24, revealed admission on 05/20/24 to the facility. Record review of Resident #198 ' s hospital history and physical dated 05/14/24, revealed a 67-year -old male diagnosed with Diabetes, End-stage renal disease, and chronic right foot wounds. Record review of Resident #198 ' s admission MDS dated [DATE], revealed a moderately impaired cognition to be able to recall or make daily decisions with a BIMS (tool used to screen and identify the cognitive condition of residents upon admission into a long-term care facility) score of 12Resident #198 was diagnosed with Diabetes. The MDS was not marked for IV Medications. Record review of Resident #198 ' s order recap dated 05/23/24, revealed ceftriaxone sodium intravenous solution. Use 1 gram intravenously one time a day for osteomyelitis for 3 weeks. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #198 ' s care plan dated 05/24/24, revealed antibiotic therapy related to infection osteomyelitis. Administer medication as ordered. Observation and interview on 05/28/24 at 9:07 AM, Resident #198 was in his room sitting down on the bed. Resident #198 had an IV with dressing on his right inner arm dated 05/24/24. Resident #198 stated he was on antibiotics and was getting them through the IV line. During an interview on 05/31/24 at 01:50 PM, with the MDS Coordinator, he stated the MDS department used nursing and CNA's information to generate the MDS for each resident. The MDS Coordinator stated anytime something happens with a resident the MDS assessment will be updated as needed. The MDS Coordinator stated if the resident was on oxygen, then it does need to be reflected in the MDS assessment. The MDS Coordinator stated residents with intravenous lines also need to be reported into the MDS assessment. The MDS Coordinator stated it was the responsibility of nursing to add them. The MDS coordinator stated there was no negative outcome, because when someone was admitted they were treating the resident for a baseline care and as the resident resides more in the facility the care plan will be updated. Record review of the facility Resident Assessment policy dated 2003, revealed, Comprehensive assessment will be completed with 14 days of admission and annually on each resident. The facility will utilize the Resident Assessment Instrument. The assessment will include - Special treatments or procedures. The results of the assessment are used to develop, review, and revise the resident's comprehensive plan of care.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49850 Based on observations, interviews, and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for three (Residents #16, #49, and #89) of 18 residents assessed for comprehensive person-centered care plans. The facility failed to ensure that Resident #16's Care plan reflected interventions in place to address his frequent falls. The facility failed to ensure that Resident #49 had a care plan in place to address chronic pain. The facility failed to ensure that Resident #89 did not have a care plan in place to address potential trauma from use of a urinary catheter. These failures could put residents at increased risk of not having their care needs met. Findings included: Resident #16 Record review of Resident #16's face sheet dated 05/29/2024 revealed he was [AGE] years old, was initially admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #16's history and physical dated 06/01/2023 revealed he had diagnoses including Diabetes Mellitus, dementia, and a Cerebrovascular Accident (a blockage of blood flow in the brain). Record review of Resident #16's quarterly MDS dated [DATE] revealed he had a BIMS score of 4 (severe cognitive impairment). Resident #16 had impaired ability to move his legs and used a wheelchair. He was dependent on staff members to stand up and needed substantial to maximal assistance to transfer between surfaces. He had fallen once with no injuries since his last MDS assessment. Record review of Resident #16's care plan date revised 12/28/2021 revealed he was at risk for falls because of balance problems and poor safety awareness. Interventions included to anticipate and meet his needs, make sure his call light was within reach and encourage him to use it, encourage him to participate in activities that promoted exercise, physical activity for strengthening and improved mobility, ensure he was wearing appropriate footwear, keep furniture in locked position, keep needed items in reach, and to be assisted with transfers by one staff member. Observation on 05/30/2024 at 11:18 AM revealed Resident #16 was asleep in bed. His bed was in a lowered position and a fall mat was at his bedside. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/31/24 at 09:50 AM LVN F revealed that interventions for Resident #16 for falls included keep him hear the nurse's station for close monitoring or at activities such as snack time, because he loved to eat. She stated that his bed was lowered and had a fall mat at his bedside when he was in bed. She said she did not have input regarding his care plan but thought that the interventions she mentioned would be part of his care plan for fall prevention. In an interview on 05/31/24 at 02:36 PM the DON revealed that Resident #16 had a history of falls and was not aware his care plan did not reflect the interventions the staff were using. She said it was important that care plans be individualized to reflect interventions used with residents. She said if care plans were not individualized, interventions used to address care needs could be missed and not followed, so residents might not get their needs met. She said that care plans were developed by the MDS nurse and updated by the IDT team. Resident #49 Record review of Resident #49's face sheet dated 05/31/2024 revealed she was [AGE] years old and was initially admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #49's History and Physical dated 4/4/2024 revealed she had a past medical history of chronic pain in her lower extremities (legs). She had paraplegia (paralysis of the lower body) and polyneuropathy (damaged nerves) for which she was prescribed Lyrica and Ibuprofen. Record review of Resident #49's quarterly MDS dated [DATE] revealed she had a BIMS score of 13 (cognitively intact). She had experienced pain frequently over the past five days that frequently affected her sleep. Her pain had caused her to occasionally limit her day-to-day activities. Her worst pain over the previous five days had been at an 8 on a zero to ten scale, with zero being no pain and ten as the worst pain. Record review of Resident #49's MAR revealed she received 3 Gabapentin capsules (300 MG each) three times a day to address autonomic neuropathy (nerve damage that can cause pain); 600 MG of Ibuprofen every 6 hours as needed for pain, and Tylenol with Codeine #3 300- 30 MG every 4 hours as needed for pain. In interviews on 05/28/2024 at 8:15 AM and on 05/29/24 at 09:49 AM, Resident #49 expressed concern that the facility had not been responsive to her requests for more effective pain medications. She said she had asked the doctor for Tylenol 4 and he said it would be ordered, but she had never received it. Record review of Resident #49's care plan last reviewed on 04/08/2024 revealed no care plan to address pain. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/31/24 at 02:37 PM the DON revealed that Resident #49 should have a care plan for her pain. She said it was important that care plans be individualized to reflect interventions used with residents. She said if care plans were not individualized, interventions used to address care needs could be missed and not followed. For Resident #49 she said lack of a care plan to address pain might result in the resident's pain being less effectively controlled than if there was a care plan. She said if care plans were not individualized, interventions used to address care needs could be missed and not followed, so residents might not get their needs met. She said that care plans were developed by the MDS nurse and updated by the IDT team. Resident #89 Record Review of Resident #89's Face Sheet dated 05/30/2024 revealed she was [AGE] year-old female, admitted to the facility on [DATE]. Record review of Resident #89's history and physical dated 03/18/2024 revealed she had a diagnosis of dementia. Record review of Resident #89's quarterly MDS dated [DATE], revealed a BIMS score of 3 (severely impaired cognition). Record review of Resident #89's care plan dated 04/16/2024, revealed Resident #89 had indwelling urinary catheter. Goals related to catheter were that she would remain free from catheter-related trauma. Interventions included changing the catheter as ordered, monitoring for any discomfort or urination and frequency, and monitor/document for pain/discomfort due to the urinary catheter . In her care plan dated 04/16/2024 with a focus on enhanced barriers precautions, there was a goal that there not be any transmission of infections to the resident related to the urinary catheter. During observation on 05/29/2024 at 04:29 PM, Resident #89 was sitting on her wheelchair in the facility hallway in front of the nursing station. Resident #89 had sediment in the urinary catheter tubing. RN on survey team was called to assist with nurse from facility to check if Resident #89 had a leg anchor strap for resident's urinary catheter tubing. During observation Resident #89 had little to no urine in catheter bag, white/yellow sediment in urine, and very strong urine order. In an interview on 05/29/2024 at 04:33 PM LVN L stated that Resident #89 does not intake a lot of water and her tubing was usually with sediment. It was confirmed that Resident #89's care plan stated she was to be encouraged liquids, and she does have history of UTI's. LVN L confirmed she was not on any antibiotics and does not have a leg anchor for her catheter on the leg. LVN L stated she will put a leg anchor strap on the resident. During an observation on 05/31/24 at 09:00 AM Resident #89 was observed sitting in her wheelchair in front of the nursing station. Resident had no leg anchor to hold the catheter in place on her leg. In an interview and observation on 05/31/24 at 09:02 AM LVN F stated Resident #89 did not have a leg anchor for the urinary catheter tubing and stated she would put one on her right away. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/31/24 at 11:27 AM the DON stated that every resident with a urinary catheter should have a care plan including use of a leg anchor. She said the leg anchor was to secure the foley to prevent pulling and harming the resident. She said the care plan should indicate how often the leg anchor would be checked. The DON said the MDS nurse or the floor nurse could add this to the resident's care plan. She said the risk of harm to the residents if a leg anchor for the urinary catheter was not on the care plan would be pulling on the urinary catheter which could cause trauma to the resident, resulting in bleeding and/or pulling out the catheter. Record review on 05/31/2024 at 01:00 PM, revealed that resident did not have any care plan regarding use of a leg anchor for her urinary catheter. Record review of the facility Nursing Policy and Procedure Manual for Catheter Care revised February 13, 2007, revealed Keep tubing off and minimize friction or movement at insertion site. Review the residents plan of care daily for changes.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49850 Based on observations, interviews, and record review the facility failed to provide necessary services to maintain good grooming and hygiene for a resident who was unable to carry out activities of daily living for 2 residents (Residents #89 and #77) out of 12 reviewed for services to maintain good grooming and hygiene. The facility failed to provide Resident #89 with removal of facial hair. The facility failed to provide personal hygiene for Resident #77 by not trimming his fingernails. This deficient practice placed residents at risk of poor hygiene and decline in residents' self-esteem. Findings included: Record Review of Resident #89's Face Sheet dated 05/30/2024 revealed she was [AGE] years old, admitted to the facility on [DATE]. Record review of Resident #89's history and physical dated 03/18/2024 revealed she had a diagnosis of dementia, hypertension, and dyslipidemia (elevated cholesterol or fats in the blood). Resident #89's activities for daily living (ADL) assistance was set up to one-person physical assist from staff. Record review of Resident #89's quarterly MDS dated [DATE], revealed a severely impaired cognition with a BIMS (tool used to screen and identify the cognitive condition of residents upon admission into a long-term care facility) score of 3. Resident #89 was diagnosed with dementia, hypertension, and dyslipidemia (elevated cholesterol or fats in the blood). Record review of Resident #89's care plan dated 04/16/2024, revealed Resident #89 had a focus of an ADL self-care performance who was unable to perform the routine task required to care for herself independently. Resident #89 had a goal Resident will maintain or improve current level of function in personal hygiene; ADL score, with an Intervention which stated Resident #89 needed assistance with personal hygiene as required; hair, shaving, and oral care as needed. Observation on 05/29/2024 at 10:52 AM revealed Resident #89 was seen outside in the hallway sitting on her wheelchair with chin facial hair about 3 cm long. Resident was unable to communicate effectively regarding her chin hair. In an interview on 05/30/2024 at 02:16 PM with CNA G stated that when the facility was short staffed (2 CNAs per wing) it was very hard to get 13-16 residents in the shower, so the residents do go days without receiving a shower. CNA G addressed missing signatures on the shower log binder dated 05/29/2024 and 05/30/2024 that was present at the nurse's station. CNA G stated that there were too many residents and not enough staff present and he can't get everyone showered as scheduled. CNA G stated that CNAs were trained to ask residents on their showering days if they would like to be shaved (male or female). If the residents say no then they do not provide the services . (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 05/30/2024 at 02:24 PM revealed Resident #89 was seen outside in the hallway still with facial hair present. Resident was not able to communicate effectively how she felt about having facial hair. In an interview on 05/31/2024 at 03:30 PM LVN F stated that the shower log information on the MAR for the CNAs labeled Other meant the CNA did not complete a full shower of the resident, or the resident received a wipe down. The LVN said this was either because the resident was having behaviors or just didn't want to be bathed. LVN F stated that it was the CNAs responsibility to address if the resident wanted to be shaved during shower time, and if the resident refused or had behaviors the CNAs were supposed to let nursing know to add to the progress notes. LVN F does not recall when Resident #89 was last showered and would have to look it up in the MAR. In an interview with Resident #89 on 05/31/2024 at 09:10 AM she was not able to communicate effectively but addressed the questions being asked about her facial hair. Resident #89 stated she felt embarrassed that she had facial hair and when she asked the CNA's how she looked they respond that she looked fine or good so she left it alone and believed that she looks good/fine since that's what the CNAs tell her. Resident #89 stated she has only been asked several times by the CNAs if she wants to be shaved and cannot recall when the last time was, they had asked her. In an interview on 05/31/2024 at 01:57 PM the Administrator stated the facility does not have a specific policy regarding female facial hair. She said the facility had a Grooming Activities policy but it does not address what the CNA's are responsible for regarding ADL care. Grooming Activities policy does not state anything about shaving or any responsibilities towards the CNA's for addressing shaving during shower time. A phone call was placed on 05/31/24 at 11:20 AM to Residents #89's daughter who is her RP (Responsible Party) did not answer, voicemail was left. In an interview on 05/31/2024 at 11:31 AM the ADON revealed staff are trained to ask the resident if they want to shave during their showers , and that Resident #89 had a pattern of resisting bathing. If a resident was resistant to shaving, it needed to be brought up with the family and depending on what was agreed on it would need to be care planned. The ADON said Resident #89's Her family has not stated anything about the facial hair. As a reasonable person concept the ADON stated she would not want to have facial hair. In an interview on 05/31/2024 at 01:50 PM the MDS Coordinator stated the purpose of a care plan was to ensure the facility was meeting the residents' needs. She said assessments were done the first day of admission and from there staff would learn from the residents and add to the care plan if needed. She said the MDS staff depended on nursing and CNAs to report or document on PCC about the residents so MDS could make a care plan for the needs of each of the residents. Nursing would also report in the morning meeting if there was an issue with a resident and then MDS would update the care plan as needed. Nursing could always update the MDS and make any changes to the care plan of the residents. Documentation was needed in order for resident behaviors to updated in the MDS . (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	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Franklin Heights Nursing & Rehabilitation	223 S Resler El Paso, TX 79912

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/31/24 at 02:16 PM with Social Worker said it was the acute floor nurse's responsibility to update the care plan if there were any changes with the resident. She said behaviors like refusal of care regarding ADLs would be addressed by nursing. The Social Worker said Resident #89 was new to the facility so a quarterly care plan update had not yet been done for her, but care planned is done immediately until they that her care plan needs to be updated. Nursing can implement it in their care plan especially of a refusal the nurse will need to update it automatically on their care plan so they can implement a care plan of the change . Resident #77 Record Review of Resident #77's Face Sheet dated 05/31/2024 revealed he was [AGE] years old, admitted to the facility on [DATE]. Record Review of Resident #77's history and physical dated 02/20/2024 he had a diagnosis of neurocognitive disorder with Lewy Bodies (clumps of proteins that build up inside certain brain cells that cause damage that affect mental capabilities, behavior, movement, and sleep) and hydrocephalus (a condition in which fluid accumulates in the brain enlarging the head and sometime times causing brain damage.) Record Review of Resident #77's MDS dated [DATE] revealed a severely impaired cognition with a BIMS (tool used to screen and identify the cognitive condition of residents upon admission into a long-term care facility) score of 4. Resident #77 was diagnosed with neurocognitive disorder with Lewy Bodies (clumps of proteins that build up inside certain brain cells that cause damage that affect mental capabilities, behavior, movement, and sleep) and hydrocephalus (a condition in which fluid accumulates in the brain enlarging the head and sometime times causing brain damage.) Review of Resident #77's care plan dated 04/16/2024, revealed needs to be checked for nail length and trim and clean on bath day and as necessary. Record review of Grievance dated 5/28/2024 for Resident #77's revealed resident needed hand and foot care. The grievance was resolved on 5/28/2024 and the CNAs were educated on their ability to cut resident nails. Observation and interview on 05/29/24 at 01:58 PM Resident #77 revealed he had long fingernails. His spouse reported she had been requesting someone to trim his fingernails but that they had not done it . Observation on 05/31/24 at 09:07 AM revealed Resident #77's fingernails had been trimmed. Interview on 05/31/24 at 10:10 am with LVN E revealed Resident #77 nails needed to be cut as soon as the staff sees they were long. She said that the facility was short staffed and that was why no one had trimmed his nails. She said that the risk of him having long nails could result in him cutting, scratching, harming himself or that he could break his nails and cause pain. Interview on 05/31/24 at 11:00 AM with the DON revealed that by not cutting the residents' nails, there was a risk of him cutting or tearing his skin and injuring himself. The DON said the expectation was for the LVNs and the CNAs to monitor the residents throughout their shift to ensure that their needs were met. (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	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Franklin Heights Nursing & Rehabilitation	223 S Resler El Paso, TX 79912

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility was unable to provide any type of policy regarding the care and training needed of staff to assure residents get the proper ADL treatment for the residents.

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	675479	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Franklin Heights Nursing & Rehabilitation	223 S Resler El Paso, TX 79912

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46998 Based on observations, interviews, and record review the facility failed to provide the necessary treatment and services based on the comprehensive assessment and consistent with professional standards of practice to promote healing and prevent worsening of pressure injuries for 1 (Resident #198) of 3 residents reviewed for pressure ulcers. LVN E failed to notify the Wound Care Nurse that Resident #198 ' s dressing for his right heel and calf was not placed according to physician orders exposing the unstageable right heel. This deficient practice could place residents at risk for worsening pressure injuries, pain, and a decline in health. Findings included: Record review of Resident #198 ' s face sheet dated 05/29/24, revealed an admission on 05/20/24 to the facility. Record review of Resident #198 ' s hospital history and physical dated 05/14/24, revealed a 67-year -old male diagnosed with Diabetes, End-stage renal disease, and chronic right foot wounds. Record review of Resident #198 ' s admission MDS dated [DATE], revealed a moderately impaired cognition with a BIMS (tool used to screen and identify the cognitive condition of residents upon admission into a long-term care facility) score of 12. Resident #198 was diagnosed with Diabetes. Record review of Resident #198 ' s order recap dated 05/22/24, revealed, Santyl external ointment 250 unit/grams. Phone - apply 1 application trans-dermally every shift related to pressure ulcer of right heel, unstageable. Hydrophera blue foam dressing over wound bed after applying Santyl and cover with bordered gauze dressing once a day and as needed. Record review of Resident #198 ' s care plan dated 05/21/24, revealed, Pressure ulcers to the lower right calf-unstageable and right heel unstageable. Ensure heels are floats with pillows, requires cushion to their wheelchair or geri-chair. There was no intervention to administer order as prescribed by physician. Care planned dated 05/21/24, revealed, had diabetes mellitus. Nurse to monitor foot care needs. Observation on 05/28/24 at 9:07 AM, LVN E was seen coming out of Resident #198 ' s room. Observation on 05/28/24 at 9:17 AM, Resident was sitting down on his bed. Right leg had a dressing from his foot up to his calf/knee area. It was dated 05/27 with the initials of the Wound Care Nurse. The dressing from the right foot was open and covering the front of the foot. The dressing had some discoloration of reddish-brown substance. The right heel was not covered with the dressing exposing the unstageable wound. (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	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Franklin Heights Nursing & Rehabilitation	223 S Resler El Paso, TX 79912

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 05/28/24 at 3:16 PM, revealed Resident #198 ' s right leg dressing had been changed. The dressing was marked 05/28 with the initials. The dressing was wrapped completely from the foot/heel up towards underneath the knee/calf area. The right leg was being floated on a wedge. Resident #198 stated the Wound Care Nurse had gone in and changed his dressing. Observation on 05/29/24 at 2:37 PM, revealed Resident #198 ' s right leg dressing had been changed with the date of 05/29 with the initialed. Dressing was wrapped up all completely from foot/heel up to the knee/calf area. Observation on 05/30/24 at 3:49 PM, revealed Resident #198 ' s right leg dressing had been changed and initialed. It was completely wrapped from the foot/heel to the underneath the knee/calf area. During an interview on 05/30/24 at 10:15 AM, with LVN E, she stated she was coming out of Resident #198 ' s room and had seen his right leg dressing. LVN E stated she had informed the Wound Care Nurse that the dressing needed to be changed. LVN E stated Resident #198 ' s dressing was not okay to be left exposing the unstageable wound. LVN E stated the risk was the wound getting worse. During an interview on 05/30/24 at 10:54 AM, with the Wound Care Nurse, he stated Resident #198 had a right heel and upper calf unstageable wounds pressure ulcers. The Wound Care Nurse stated he conducts daily wound care on Resident #198 but had not got to him yet as he was doing other wound care on other residents. The Wound Care Nurse stated on 05/28/24, LVN E did not notify him about the dressing needing to be re-done or looked at. The Wound Care Nurse stated the wound being exposed and touching the floor was an infection control issue. The Wound Care Nurse stated the LVN E should have changed the dressing or notified him immediately. During an interview on 05/30/24 at 1:13 PM, with the DON, she stated Resident #198 wound dressing for his right leg unstageable wound needed to be wrapped up completely. The DON stated if a nurse seeing a resident who has a dressing that needs to be re-done should immediately change it or notify the Wound Care Nurse immediately. The DON stated not changing the dressing or notifying the Wound Care Nurse could be a risk of infection, especially for Resident #198 who had his heel exposed and touching the floor. During an interview on 05/31/24 at 4:33 PM, with the Wound Care Nurse, he stated the upper calf wound was healing fast and the heel was improving but slowly and not getting worse. Record review of the facility Skin Integrity Management policy dated 10/05/16, revealed, Wound care should be perform as ordered by the physician. Record review of the facility Pressure Injury: Prevention, Assessment and Treatment dated 08/12/16, revealed, Nursing personnel will continually aim to maintain the skin integrity, tone, turgor and circulation to prevent breakdown, injury and infection. Record review of the facility Skin Assessment policy dated 08/15/24, revealed, It was the policy of this facility to establish a method whereby nursing can assess a resident ' s skin integrity to allow of appropriate intervention be initiated in a timely manner.

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	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Franklin Heights Nursing & Rehabilitation	223 S Resler El Paso, TX 79912

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49850 Based on observations, interviews, record review the facility failed to ensure that a resident who was continent of bladder and bowel on admission received services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence was not possible to maintain for 1of 5 (Resident #89) residents reviewed for urinary catheter. The facility failed to ensure Resident #89's catheter leg strap was in place to secure the catheter. This failure could place residents with foley catheter at risk of catheter pulling causing pain and/or infection. Findings include: Record Review of Resident #89's Face Sheet dated 05/30/2024 revealed she was [AGE] years old, admitted to the facility on [DATE]. Record review of Resident #89's history and physical dated 03/18/2024 she had a diagnosis of dementia, hypertension, and dyslipidemia (elevated cholesterol or fats in the blood). Resident #89's activities for daily living (ADL) assistance was set up to one-person physical assist from staff. Record review of Resident #89's quarterly MDS dated [DATE], revealed a severely impaired cognition BIMS (tool used to screen and identify the cognitive condition of residents upon admission into a long-term care facility) score of 3. Resident #89 was diagnosed with dementia, hypertension, and dyslipidemia (elevated cholesterol or fats in the blood). Record review of Resident #89's care plan dated 04/16/2024, revealed Resident #89 had a focus of on ADL self-care performance, and was unable to perform the routine tasks required to care for herself independently. Resident #89 had a goal Resident will maintain or improve current level of function in personal hygiene; ADL score, with an intervention which stated Resident #89 needs assistance with personal hygiene as required; hair, shaving, and oral care as needed. During an observation on 05/29/2024 at 04:29 PM, Resident #89 was sitting on her wheelchair in the facility hallway in front of the nursing station. Resident #89 had catheter tubing hanging extremely low to where it was almost touching the floor, and sediment in the tubing. RN on survey team was called to assist with the nurse from the facility to check if resident #89 had a leg anchor strap for residents tubing. During the observation resident #89 had little to no urine in catheter bag, white/yellow sediment in urine, and very strong urine order. In an interview on 05/29/2024 at 04:33 PM LVN L, stated that resident #89 does not intake a lot of water and her tubing was usually with sediment. Confirmed that Resident #89's care plan stated she was to be encouraged liquids, and she does have history of UTI's. LVN L confirmed she is not on any antibiotics and does not have a leg anchor for catheter on the leg. LVN L stated she will put a leg anchor strap on resident. (continued on next page)

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	675479	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Franklin Heights Nursing & Rehabilitation	223 S Resler El Paso, TX 79912

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 05/31/24 at 09:00 AM Resident #89 was observed sitting in her wheelchair in front of the nursing station Resident had no leg anchor for catheter strap on leg. In an interview on 05/31/24 at 09:02 AM LVN F stated Resident #89 does not have an anchor on and stated she will put one on her right away. Resident #89 had a lot of sediment in her tubing again. LVN F stated that she always has sediment in her tubing because she did not drink a lot of water, and it was in her care plan to be encouraged to drink liquids. The LVN stated it was the responsibility of the CNAs to document how much liquid the resident took in and the nurses would record how much she puts out when that bag is changed on every shift or more if needed . Received catheter policy on 05/31/24 at 11:11 AM, policy of catheter care was provided but requested if facility has another policy regarding the leg anchor strap for a catheter, as the policy provided did not have any information regarding the leg anchors for catheters. In an interview on 05/31/24 at 11:27 AM the ADON stated that every resident that has a catheter should have a leg anchor for the catheter. Staff are supposed to assist with making sure residents have the leg anchor, if it is not there, they need to replace it. Some residents are scheduled to be checked every shift, depending on their care plans, and this would be checked off on the MAR. The leg anchor is to secure the foley to prevent pulling and harming the resident. She said the risk of harm to the residents if staff did not ensure the resident had a leg strap to secure the urinary catheter would be pulling on the catheter which could cause trauma to the resident, bleeding, and/or pulling out the catheter. Record review of the facility Nursing Policy and Procedure Manual for Catheter Care revised February 13, 2007, revealed Keep tubing off and minimize friction or movement at insertion site. Review the residents plan of care daily for changes.

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	675479	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Franklin Heights Nursing & Rehabilitation	223 S Resler El Paso, TX 79912

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46998 Based on observations, interviews, and record review the facility failed to ensure residents received parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders for 1 (Resident #198) of 2 residents reviewed for Midline/PICC (Peripherally Inserted Central Catheter) care. Resident #78 midline (intravenous catheter) dated 05/20/2024, the dressing edges where loose and coming off, dressing had dried blood towards the bottom of the dressing, and was dated 05/20/24. This failure placed residents at risk of developing an infection. Findings included: Record review of Resident #78 ' s face sheet dated 05/28/24, revealed an admission on 06/08/23 to the facility. Record review of Resident #78 ' s facility history and physical dated 06/08/23, revealed, a [AGE] year-old male diagnosed with borderline Diabetes and total knee replacement, and infection of prosthesis (a device such as an artificial leg, that replaces a part of the body). Record review of Resident #78 ' s admission MDS dated [DATE], revealed an intact cognition to be able to recall or make daily decision with a BIMS (tool used to screen and identify the cognitive condition of residents upon admission into a long-term care facility) score of 15. Resident #78 was diagnosed with Diabetes Mellitus, and infection due to internal right knee prosthesis. Resident #78 was marked for antibiotic use and IV medications. Record review of Resident #78 ' s order recap dated 05/07/24, revealed, PICC Line Dressing Change every 7 days one time a day every Tuesday, Wednesday - PICC Line dressing change every 7 days. Record review of Resident #78 ' s care plan dated 04/24/24, revealed had a skin soft tissue/cellulitis infection. Administer antibiotic as per medical doctor ' s orders. Perform any dressing changes as ordered. Observation and interview on 05/28/24 at 9:07 AM, Resident #78 was in his room lying down on the bed. Resident #78 had an IV with dressing on his left inner arm dated 05/20/24. The dressing edges were loose and coming off. Inside the dressing there was dried blood. Resident #198 stated he was on antibiotics and was getting them through the IV line. During an interview on 05/28/24 at 11:39 AM, with Resident #78, he stated the nurses had changed his dressing from his left arm to his right arm. Resident #78 stated he was receiving antibiotics for infection he had. During an interview on 05/30/24 at 9:47 AM, with Resident #78, he stated the dressing was changed on 05/29/24. Resident #78 stated the nurse came in and changed his dressing. (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	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Franklin Heights Nursing & Rehabilitation	223 S Resler El Paso, TX 79912

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/30/24 at 9:50 AM, with LVN E, she stated Resident #198 was on antibiotics and was receiving them intravenous due to an infection. LVN E stated the IV line was changed from the left side arm to the right-side arm on 05/20/24. LVN E stated the dressing should have already been changed. LVN E stated it was expected for the nurses to be changing the dressing as ordered by the physician. LVN E stated that not changing the dressing could lead to an infection. During an interview on 05/31/24 at 1:13 PM, with the DON, she stated if a physician order stated to change the dressing every Tuesday and Wednesday then it needed to be changed out. The DON stated failure to follow the physician order could be a risk of infection for Resident #78.

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	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Franklin Heights Nursing & Rehabilitation	223 S Resler El Paso, TX 79912

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46998 Based on observations, interviews, and record review the facility failed to ensure that a resident who needs respiratory care was provided such care, consistent with professional standards of practice for 2 (Resident #88 and Resident #196) of 5 residents observed for oxygen management. Resident #88 and Resident #196 were on oxygen and did not have oxygen signs posted outside their bedrooms (room [ROOM NUMBER] and room [ROOM NUMBER]). This failure could place residents on oxygen therapy at risk of receiving incorrect or inadequate oxygen support and decline in health. Findings included: Resident #88 Record review of Resident #88 ' s face sheet dated 05/29/24, revealed an admission on 03/22/24 and re-admission on 04/30/24 to the facility. Record review of Resident #88 ' s facility history and physical dated 03/22/24, revealed, a [AGE] year-old male diagnosed with tongue and thyroid cancer and alcohol cirrhosis. Record review of Resident #88 ' s admission MDS dated [DATE], revealed severely impaired cognition to be able to recall or make daily decision with a BIMS (tool used to screen and identify the cognitive condition of residents upon admission into a long-term care facility) score of 5. Resident #88 was diagnosed with cancer, muscle weakness (no muscle strength), and adult failure to thrive. Does not have trouble with shortness of breath. The MDS was not marked for oxygen therapy. Record review of Resident #88 ' s order recap dated 05/01/24, revealed oxygen via nasal cannula at 2 liters per minute via nasal cannula continuously every shift. Record review of Resident # ' s care plan dated 05/13/24, revealed oxygen therapy related to shortness of breath. Oxygen at blank (the amount of oxygen was not added and left blank) liters per minute per nasal cannula. Observation on 05/28/24 at 8:18 PM, the oxygen concentrator was running in Resident #88 ' s room and could be heard outside in the hallway. No Oxygen Sign was put up outside of Resident #88 ' s room. Observation and interview on 05/28/24 at 8:39 AM, Resident #88 was sitting down on her wheelchair eating breakfast. Resident #88 was wearing a nasal cannula with the concentrator on. Resident #88 stated she was on oxygen and needed it to breathe. Resident #196 (continued on next page)

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	675479	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Franklin Heights Nursing & Rehabilitation	223 S Resler El Paso, TX 79912

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #196 ' s face sheet dated 05/29/24, revealed, admission on 05/23/24 to the facility. Resident #196 was a [AGE] year-old female diagnosed with acute respiratory failure with hypoxia (a condition where you don ' t have enough oxygen in the tissues in your body). Record review of Resident #196 ' s admission MDS dated [DATE], revealed, an intact cognition to be able to recall or make daily decisions BIMS (tool used to screen and identify the cognitive condition of residents upon admission into a long-term care facility) score of 15. Resident #196 was diagnosed with respiratory failure. Was not marked for shortness of breath. Oxygen therapy was not marked. Record review of Resident #196 ' s order recap dated 05/23/24, revealed, may use oxygen at 2 liters per minute via nasal cannula for oxygen saturations greater than 90 percent. RA May attempt to wean off oxygen every shift. Record review of Resident #196 ' s care plan dated 05/24/24, revealed, oxygen therapy. Oxygen at blank (it was left blank) liters per minute per nasal cannula. Resident #196 has shortness of breath. Notify the charge nurse if the resident was having trouble breathing. Observation on 05/28/24 at 8:17 AM, the oxygen concentrator was running in Resident #196 ' s room and could be heard outside in the hallway. No Oxygen Sign was put up outside of Resident #196 ' s room. During an interview on 05/28/24 at 8:37 AM, with Resident #196, he stated he was on oxygen and had to use it. During an interview on 05/30/24 at 10:04 AM, with LVN E, she stated oxygen signs are placed outside of resident ' s rooms that are using oxygen. LVN E stated it lets everyone know not to smoke. LVN E stated not having the oxygen signs put up could be a risk of blowing up in the room. LVN E stated the nurses were responsible for putting up the oxygen signs for residents who are on oxygen. During an interview on 05/31/24 at 1:13 PM, with the DON, she stated oxygen signs alert everyone that oxygen was used and for precautions. The DON stated it was the responsibility of the nurses to put up the oxygen signs outside of residents who are on oxygen rooms. The DON stated the risk was a fire hazard. Record review of the facility Oxygen Administration policy dated 02/13/07, revealed, Place NO SMOKING signs in area when oxygen was administered and stored.

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	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Franklin Heights Nursing & Rehabilitation	223 S Resler El Paso, TX 79912

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34486 Based on interview and record review the facility failed to ensure that pain management was provided to residents who require such services, consistent with professional standards of practice and the residents' goals and preferences for one (Resident #49) of 12 residents reviewed for pain control . The facility failed to ensure that Resident #49's request, and physician's order to administer Tylenol 4 (Acetaminophen-Codeine Oral Tablet 300-60 MG) were carried out in a timely manner. This failure could put residents at increased risk for pain and decreased quality of life. Findings included: Record review of Resident #49's face sheet dated 05/31/2024 revealed she was [AGE] years old and was initially admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #49's History and Physical dated 4/4/2024 revealed she had a past medical history of chronic pain in her lower extremities (legs). She had paraplegia (paralysis of the lower body) and polyneuropathy (damaged nerves) for which she was prescribed Lyrica and Ibuprofen. Record review of Resident #49's quarterly MDS dated [DATE] revealed she had a BIMS score of 13 (cognitively intact). She had experienced pain frequently over the five lookback days that frequently affected her sleep. Her pain had caused her to occasionally limit her day-to-day activities. Her worst pain over the previous five days had been at an 8 on a zero to ten scale, with zero being no pain and ten as the worst pain. Record review of Resident #49's MAR dated 5/5/2024 revealed she received 3 Gabapentin capsules (300 MG each) three times a day to address autonomic neuropathy (nerve damage that can cause pain); 600 MG of Ibuprofen every 6 hours as needed for pain, and Tylenol with Codeine #3 300- 30 MG every 4 hours as needed for pain. In interviews on 05/28/2024 at 8:15 AM and on 05/29/24 at 09:49 AM , Resident #49 expressed concern that the facility had not been responsive to her requests for more effective pain medications. She said she had been taking Tylenol 3 but had asked the doctor for Tylenol 4. She said the doctor said it would be ordered, but she had never received it. In an interview on 05/29/24 at 09:49 AM Resident #49 she said she asked the doctor for Tylenol 4 for her pain. She said the doctor said it would be ordered, but it had been a week or two since she had asked the doctor for the increase in medications . She said she wanted to change to a different doctor because her current physician was not responding to her needs. Record review of Resident #49's nursing progress note by LVN F dated 4/11/24 at 1:31 PM revealed the resident had informed Physician O that the Tylenol #3 was not working and wanted Tylenol #4. Physician O informed the nurse to change the order and the order was changed. (continued on next page)

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	675479	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #49's April 2024 MAR revealed an order for Acetaminophen-Codeine Oral Tablet 300- 60 MG one tablet by mouth every 4 hours as needed for pain. No medication was documented as having been administered. Record review of Resident #49's nursing progress note by LVN F dated 4/16/24 at 9:34 AM revealed a new order was received from Physician O's nurse practitioner to discontinue the Tylenol #4 order and switch back to the Tylenol #3 order as before. The note did not give a reason for the change. Record review of Resident #49's physician orders revealed an order dated 05/15/2024 and discontinued on 05/21/2024 for Acetaminophen-Codeine 300-60 MG Tablet to be given every four hours as needed for pain. Resident #49 had another order for Acetaminophen-Codeine 300-60 MG Tablet to be given every four hours as needed for pain dated 05/26/2024 and 5/28/24. Review of Resident #49's MAR for May revealed that Acetaminophen-Codeine 300-60 MG Tablets were not administered during those time periods. Record review of Resident #49's nursing progress note by LVN F dated 5/21/24 revealed an order was received from Physician O's nurse practitioner to discontinue the Tylenol #4 at that time. Record review of Resident #49's nursing progress note by LVN F dated 05/30/2024, revealed she spoke to Physician O who asked the nurse to contact the pharmacy to see if they need a triplicate or a signed prescription on a prescription pad, and that the LVN learned from the pharmacy that the pharmacy was unable to get Tylenol #4 because it had been on back order for months and unaware when will be able to get it. LVN F's note indicated that she informed Physician O of this issue. In an interview on 05/30/2024 at 12:00 PM, Physician O stated he had written an order for Resident #49's Tylenol #4 but was just told that it was on back-order the past two months per pharmacy. He stated that Resident #49had been on Tylenol III but wanted Tylenol IV . In an interview on 05/31/24 at 09:34 AM, LVN F revealed she had received Resident #49's Physician order for Tylenol #4 and that she had entered the order, and it should appear on Resident #49's April 2024 MAR. She stated that the status right now was that the order was discontinued. She said she called the pharmacy on 05/30/2024 to see if the pharmacy needed a prescription or a triplicate and was told the medication was on back order. LVN F said the resident was sent to the pain center and had been getting Tylenol 3 as needed. The LVN said the Tylenol 3 was usually effective not in alleviating the pain but in dropping the level of the pain. She said she had spoken to the ADON, with a corporate level staff member, and with the DON about the issue in getting the resident the Tylenol 4. LVN F stated that the potential impact on the resident was that she could lose confidence in the facility and doctor (now she wants to switch). She said she did not know if the resident's pain control would be better. She said the resident could have depression due to being in constant pain and less motivation for movement or activities. (continued on next page)

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	675479	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Franklin Heights Nursing & Rehabilitation	223 S Resler El Paso, TX 79912

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 5/31/24 at 3:34 PM, the DON revealed that the nurses should have been following up to see what the delay was in obtaining Tylenol #4 for Resident #49. If they had followed up, they might have received the pain medication or heard sooner it was on back order and sought a solution. The DON said that the risk to the resident was that her pain may not have been as well-controlled as it could have been. A policy and procedure on pain management was requested . Record review of the facility policy Pain Management, Assessment Scale dated 5/25/16 revealed complaints of pain would be assessed and effectively managed through prescribed medications and comfort measures and all available resources of the facility.

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	675479	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Franklin Heights Nursing & Rehabilitation	223 S Resler El Paso, TX 79912

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. 46998 Based on observation, interview, and record review the facility failed to ensure nurse staffing data was posted and readily accessible to residents and visitors for thirty-two of fifty-two days reviewed for nurse staffing information. The facility failed to post the required staffing information for [NAME] & East Wings- East Wing - 10/07/23, 10/21/23, 10/22/23. West Wing - 10/07/23, 10/21/23, 10/22/23. East Wing - 11/04/23, 11/18/23, 11/25/23, 11/26/23. West Wing - 11/04/23, 11/12/23, 11/18/23, 11/19/23, 11/25/23, 11/26/23 East Wing - 12/01/23, 12/02/23, 12/09/23, 12/10/23, 12/23/23, 12/24/23, 12/30/23, 12/31/23. West Wing - 12/02/23, 12/03/23, 12/09/23, 12/10/23, 12/23/23, 12/24/23, 12/30/23, 12/31/23. This failure could place residents, their families, and facility visitors at risk of not having access to information regarding staffing data and facility census. Findings include: Observation on 05/31/24 at 9:26 AM, of staffing posting revealed, missing information of number of RNs and LVNs scheduled to work and RN and LVN hours worked for both facility wings (West and East Wing). They are as following: East Wing - 10/07/23, 10/21/23, 10/22/23. West Wing - 10/07/23, 10/21/23, 10/22/23. East Wing - 11/04/23, 11/18/23, 11/25/23, 11/26/23. West Wing - 11/04/23, 11/12/23, 11/18/23, 11/19/23, 11/25/23, 11/26/23 East Wing - 12/01/23, 12/02/23, 12/09/23, 12/10/23, 12/23/23, 12/24/23, 12/30/23, 12/31/23. West Wing - 12/02/23, 12/03/23, 12/09/23, 12/10/23, 12/23/23, 12/24/23, 12/30/23, 12/31/23. During an interview on 05/31/24 at 1:13 PM, with the DON, she stated the nurses were responsible for filling out the posted staffing. The DON stated not filling out the staffing postings the family, residents, and visitors would not know if there were staff to provide service to the residents. The DON stated the nurses were responsible for filling out the staffing postings. (continued on next page)

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	675479	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Franklin Heights Nursing & Rehabilitation	223 S Resler El Paso, TX 79912

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility document Mandatory Postings dated 5/16/2019 documented in part that the posting named Daily Staffing by shift of Licensed and Unlicensed Nursing Staff was listed as mandatory.

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	675479	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Franklin Heights Nursing & Rehabilitation	223 S Resler El Paso, TX 79912

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20026 Based on observation, interview, and record review the facility failed to provide pharmaceutical services that assured the accurate acquiring, receiving, dispensing, safe and secure storage of medications for 1 (Resident #10) of 6 residents reviewed for medication administration; and 1 of 3 medications carts (used in Zone 4 & Zone 5) reviewed for medication storage. -The facility failed to administer medication to Resident #10, according to physician ' s order. -The facility failed to follow the facility ' s policy and procedure on drug destruction by not providing the administrator copies of Individual Control Drug Records for 21 of 31 controlled substances to reconcile with the pharmacist at time of drug destruction. -The facility failed to keep medication drawers free of dust and paper particles in medication. These failures could place residents at risk of inadequate therapeutic outcomes and worsened health conditions; could place residents at risk of drug diversion. The findings include: Resident #10 Review of Resident #10 ' s Admission Record dated [DATE], revealed initially admitted on [DATE]; readmitted on [DATE]. Review of Resident #10 ' s History & Physical dated [DATE] revealed a [AGE] year-old female with a past medical history of diabetes mellitus type 2, end-stage renal disease stage III, and hypertension. Review of Resident #10 ' s Quarterly MDS dated [DATE], revealed hearing-adequate, clear speech, makes self-understood, understands others, vision-highly impaired, BIMS summary score 15-Cognitively intact; Active Diagnoses: Hypertension, End-Stage Renal Disease, Diabetes Mellitus. Hemodialysis. Review of Resident #10 ' s Care Plan dated [DATE] revealed, Risk for cardiac complications r/t hypertension. Approaches: Administer medications as ordered. Obtain B/P as ordered and PRN. The resident received dialysis three times a week. Review of Resident #10 ' s Physician Order Summary Report dated [DATE], revealed, Losartan give 100 mg by mouth one time a day for hypertension. Review of Resident #10 ' s MAR dated [DATE], revealed Losartan give 100 mg by mouth one time a day for hypertension in AM. Review of Pharmacist Drug Regime Reviews for [DATE] and [DATE] for Resident #10 did not document any recommendations regarding Losartan. (continued on next page)

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	675479	A. Building B. Wing	05/31/2024

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on [DATE] at 9:24 AM, during the Medication Pass Observation revealed, Medication Aide M, held Losartan 100 mg one tablet that was scheduled to administered in AM, according to physician ' s orders. Interview on [DATE] at 11:25 AM, with Medication Aide (MA) M, stated, I did not ask LVN N on [DATE], if I needed to hold the Losartan if the order did not have parameter. I only asked the nurse to confirm if I needed to hold the Amlodipine and Hydralazine because the resident's blood pressure was ,d+[DATE] and the order documented to hold the medications if the DBP was > (less than) 60. Interview on [DATE] at 11:28 AM, with LVN N revealed MA M should not have held the Losartan on [DATE] in the morning because the physician's order did not document parameters to hold the medication, like the orders for the Amlodipine and Hydralazine that documented to hold the medication if the resident's DBP was >60. Observation on [DATE] at 11:35 AM, revealed physician was at the facility and LVN N asked the physician in the presence of the surveyor if Losartan needed to be held if the order did not have parameter, like the orders for the Amlodipine and Hydralazine to hold the medication for SBP <110 or DBP <60. MD stated Losartan needed to be administered as ordered since the order did not have parameters to hold the medication. Interview and record review on [DATE] at 9:05 AM, with the DON and RN Regional Compliance Nurse revealed Physician Order Summary Report dated [DATE] for Resident #10, revealed order date [DATE] Losartan give 100 mg by mouth one time a day for hypertension in AM. RN Regional Compliance Nurse confirmed Medication Aide M, should have administered Losartan 100 mg as ordered because the physician order did not have parameters to hold the medication. Drug Destruction Observation and Iinterview on [DATE] at 9:17 AM, with DON and Corporate Nurse Consultant revealed controlled substances were kept in a locked cabinet in the DON's office. The DON said, The nurse will give a copy of the Individual Control Drug Record that has the count for each controlled substance stored in the locked cabinet in the DON ' s pending drug destruction. The Administrator keeps the Individual Control Drug Records in a binder in her office and is used to reconcile the controlled substances at time drug of destruction. I keep the original Individual Control Drug Record for each controlled substance stored in the locked medication cabinet under double lock cabinet in my office pending drug destruction. I keep the original Individual Control Drug Record for each controlled substance stored in the locked medication cabinet under double lock cabinet in my office pending drug destruction. I keep the original Individual Control Drug Record for each controlled substance stored in the locked medication cabinet under double lock cabinet in my office pending drug destruction. During drug destruction, the administrator will provide copies of the Individual Control Drug Records in her binder to the pharmacist to reconcile with the controlled medications stored in the locked medication cabinet at the time of drug destruction. This is done to ensure that all controlled substances that are pending drug destruction are accounted for at time of drug destruction with consulting pharmacist and two witnesses to prevent drug diversion. Surveyor requested the binder from Administrator's office to reconcile the controlled substances in the locked medication cabinet located in the DON's office with Corporate Nurse Consultant and the DON. (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	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Franklin Heights Nursing & Rehabilitation	223 S Resler El Paso, TX 79912

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and record review on [DATE] at 9:17 AM, RN Corporate Nurse Consultant and the DON, revealed there were 31 controlled substances stored in a locked metal cabinet located in DON's office pending drug destruction. All the controlled substances had an Individual Control Drug Record with a count for each medication and signed by licensed nurse and DON. Review of Control Drug Record with DON revealed that all medications were accounted for, and actual counts were correct. Review of the Administrator's binder revealed that she did not have a copy of the Individual Control Drug Records for 21 of 31 controlled substances that were pending drug destruction. The Corporate Nurse Consultant placed a telephone call to the Administrator in the presence of the surveyor, to ask if she had any other Control Drug Records in her office for controlled substances that were pending drug destruction in the DON's office. Corporate Nurse Consultant stated, Administrator stated she did not have any other Control Drug Records in her office. In an interview on [DATE] at 3:38 PM, with the Administrator revealed that she did not know why she was missing 21 Individual Control Drug Records in her binder for the 31 controlled substances that were stored in the locked medication cabinet in the DON's office pending drug destruction. Administrator confirmed that this was a system that they had in the facility to ensure that all controlled substances were accounted for by the pharmacy consultant during drug destruction to prevent drug diversion of controlled substances. Medication Cart In an observation and interview on [DATE] 3:47 PM, LVN N revealed the medication cart used in Zone 4 and Zone 5 had dried stains and small particles in one of the drawers where medication blister packets are stored. LVN N stated medication carts should be cleaned by the nurses at least once a week. Review of facility's policy and procedure revised [DATE], provided by RN Corporate Nurse Consultant on [DATE] revealed, Policy: It is the policy of this facility to destroy dangerous and controlled medications according to the State of Texas law. Drugs to be destroyed will be destroyed under the supervision of a consultant pharmacist and at least one of the following: Director of Nursing, Assistant Director of Nursing or Administrator. Nursing staff will submit to the Director of Nursing any controlled medication and any applicable log that has expired, been discontinued by physician or that had been prescribed to a resident who no longer resides at the facility. The nurse submitting the discontinued medication will verify along with the Director of Nursing that the amount of medication remaining matches the log. After verification, both the nurse and the Director of Nursing will sign the log. The nurse will make a copy of the signed log and provide it to the administrator. The Director of Nursing will maintain the original log and medication. The Director of Nursing will log medications submitted for destruction. All controlled medications submitted to the Director of Nursing will be kept under a double lock system. During drug destruction, the administrator will provide copies of the controlled mediation logs to the pharmacist to reconcile with the controlled medications ready for destruction.

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	675479	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Franklin Heights Nursing & Rehabilitation	223 S Resler El Paso, TX 79912

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20026 Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals in accordance with manufacturer ' s specifications for of 3 medication carts (Zone 4 /Zone 5) reviewed for medication storage and handling of medications. -The facility failed to date Glucometer Normal/High Control Solutions when opened according to manufacturer specifications in Zone 4/Zone 5. These failures could affect diabetic residents that received medications from the facility. The findings include: Observation and interview on [DATE] 3:42 PM, LVN N revealed Glucose Control Solutions had not been dated when opened. LVN N confirmed that the manufacturer ' s specification on the Glucose Control Solution bottles documented to discard testing solutions 3 months after first opening. LVN N, stated licensed staff had been trained to write the date on the box and/or the control solution bottles when opened. Interview on [DATE] at 3:00 PM, the DON revealed licensed staff had been trained to date the bottles of the Glucose Control Testing Solution when opened and discarded according to manufacturer ' s specifications. Review of Glucometer policy revised February 13, 2007, provided by RN Corporate Nurse Consultant revealed, Quality of Control Solutions and Test Strips: Bottles must be dated when opened. Control solution is good for 3 months then discard. Review of the Blood Glucose Monitoring System User ' s Guide revealed record the date on the bottle when opening a new bottle of control Solution. Discard the unused control solution three months after the opening date. Always check the expiration date. DO NOT use control solutions if they are expired.

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	675479	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Franklin Heights Nursing & Rehabilitation	223 S Resler El Paso, TX 79912

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49854 Based on observations, interviews, and record review the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for sanitation and food storage. -The facility failed to keep 1 gallon bottle of Soy sauce stored on a metal rack in the walk-in refrigerator free of dried drippings around the lid. -The facility failed to keep one plastic container with jelly stored on a metal rack in the walk-in refrigerator free of dried food residue on the lid. -The facility failed to store foods in the refrigerator in sealed containers. There was ground beef thawing inside the refrigerator and blood drippings were found on the floor where the meat was placed. This failure could affect residents by placing them at risk of food borne illness. Findings include: Observation and interview on 5/28/24 at 8:15 a.m., the Dietary Manager in the walk-in refrigerator, revealed that 1 plastic gallon of Soy Sauce had dried drippings around the cap. One large plastic container that was labeled with Jelly and dated with use by date of 5/31, had dried food residues on the lid. The Dietary Manager stated those containers should be cleaned after each use. They are not supposed to be like that. When asked what the potential harm for the residents could be, the Dietary Manager stated, that can contaminate the rest of the food inside the refrigerator creating cross contamination, and there are risks for food born illness to the residents in the facility. The Dietary Manager stated, these containers that have liquids in them should be placed at the bottom of the metal rack in case there are spills, they fall to the floor and the rest of the food is not contaminated by the substance. I will in-service the staff to clean the bottles every time they are done using them and will move the bottles to the bottom of the metal rack.There was a metal tray at the bottom of a metal rack that had a tube of ground beef on it. The metal tray with the ground beef was not covered and the meat was releasing blood from the package. The Dietary Manager stated, that is not supposed to be like that. When asked what the potential harm for the residents could be, the Dietary Manager stated, that can contaminate the rest of the food inside the refrigerator creating cross contamination, and there are risks for food born illness to the residents in the facility. Observation and interview on 5/28/24 at 8:31 a.m., the Dietary Manager in the kitchen, revealed that the oven to the left side of the stove was not in operational conditions and that the door was being secured with a yellow and red bungee cord with metal hooks. It also revealed that the stove to the right was missing the burner knobs to regulate the flames of the burners. The Dietary Manager stated that the oven had been in that condition for about 3 months and said that he had a work order in place to replace the burner knobs from the stove and to repair the oven and the door. (continued on next page)

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	675479	A. Building B. Wing	05/31/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 5/28/24 at 9:03 a.m., the Dietary Supervisor, asked for the procedure on how they were supposed to thaw meat such as the ground beef that was located in the walk-in refrigerator, she stated I take the meat out of the freezer and put it in the walk-in refrigerator for 4 days so it has time to completely thaw before using it. When she was asked about the potential risk for the residents for having dried blood drippings on the floor she stated, there can be cross contamination and can get the residents sick. An observation inside the walk-in refrigerator revealed that there were dried up blood stains on the floor directly below the metal tray that had the thawing ground beef tube of meat and on the walls to the side and back of the metal rack. The Dietary Manager stated, that on the wall it ' s dried ketchup, but yes, that on the floor looks like dried up blood and it ' s not supposed to be like that. When asked what the potential harm for the residents could be, the Dietary Manager stated, again, that can contaminate the rest of the food inside the refrigerator creating cross contamination, and there are risks for food born illness to the residents in the facility. Record review of the facility policy Infection Control dated 2012 revealed that all employees will practice infection control in the food and nutrition services department and maintain sanitary food preparation. All dietary service employees will follow infection control policies as established and approved by the infection control committee. The policies and procedures provided by the facility did not address the safe storage of food in the refrigerator to prevent food borne illness. Record review of the facility policy Infection Control dated 2012 revealed that the facility will provide clean and sanitized equipment for food preparation. The facility will clean all food service equipment in a sanitary manner. Policies and Procedures provided by the facility did not address hygiene and sanitation of the refrigerator. Record review of In-Service Training Attendance Roster dated 02/01/2024 addressed the instructions for daily, weekly and monthly cleaning schedules. Instructions are as follow: The dietary services manager will be responsible for the scheduling of personnel on cleaning sheets. Items not listed but part of the kitchen should be added by the dietary service manager in the space provided on each sheet to customize the cleaning schedule for each kitchen. The instructions provided did not address the sanitation or cleaning schedule for the refrigerator.

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	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Franklin Heights Nursing & Rehabilitation	223 S Resler El Paso, TX 79912

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 46998 Based on interviews and record review the facility failed to be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident for 1 of 1alleged allegation of stealing of medications reviewed for allegations of misappropriation of property. The facility failed to ensure the DON followed the internal abuse policy, report allegations of abuse to State Office, and conduct thorough abuse allegation investigation. These failures could place all residents at risk of continued abuse by not immediately following the facility policy of abuse, neglect, exploitation, or misappropriation - reporting and investigating. Findings included: During an interview on 05/30/24 at 2:32 PM, with the DON, she stated she had received a report from LVN D. The DON stated LVN D tends to makes malicious allegation towards other nurses. The DON stated LVN D made a malicious report to her on 05/28/24, regarding LVN K taking medications from the residents. The DON stated she followed up with LVN K and no one had reported any missing medications. The DON stated she had just started her investigation. The DON stated she did not report it to the Administrator. The DON stated as per the facility policy and protocol it had to be reported to the state agency, which was not reported too. During an interview on 05/30/24 at 3:15 PM, with the Administrator, Regional Compliance Nurse, and the DON. The Regional Nurse stated during a conversation with the DON on 05/30/24, the DON had reported to her that LVN D had told her that LVN K was stealing medications from the residents. The Administrator stated she was unaware of the situation. The Administrator and Regional Compliance Nurse stated it should have been reported to the state agency when the facility received the allegation. Record review of the facility Abuse/Neglect policy dated 03/29/18, revealed, The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. It was each individual ' s responsibility to recognize, report, and promptly investigate actual or alleged abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property abuse and situations that may constitute abuse or neglect to any resident in the facility. Misappropriation of Resident Property: the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident ' s belongings or money without the resident ' s consent. Reporting - Any person having reasonable cause to believe an elderly or incapacitated adult was suffering from abuse, neglect, or exploitation must report this to the DON, Administrator, state and or adult protective services. State law mandates that citizens report all suspected cases of abuse, neglect, or financial exploitation of the elderly and incapacitated persons. (continued on next page)

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	675479	A. Building B. Wing	05/31/2024

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility employees must report all allegations of abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident properly or injury of unknown source to the facility administrator. The facility administrator or designee will report to HHSC all incidents that meet criteria of Provider Letter 19-17 dated 07/10/19. Record review of the facility Event Reporting: Completion Of policy and procedure not dated revealed, Investigation: The investigation should be completed by the DON/Administrator or designee. The investigation report documents a though investigation of the events including person, equipment, and materials involved. The investigation report must include what actions were taken to prevent subsequent Events and signatures of the individuals as indicated on the form. Record review of facility Long Term Care Regulatory Provider Letter dated 07/10/19, revealed, A Nursing facility must report to HHSC the following types of incidents, in accordance with applicable state and federal requirements: Abuse, Neglect, Exploitation, Misappropriation, Drug Theft, Death due to unusual circumstances, Fire, Emergency situations that pose a threat to resident health and safety. State and federal law requires an owner or employee of nursing facility who has cause to believe that the physical or mental health or welfare of a resident has been or may be adversely affected by abuse, neglect, or exploitation caused by another person to report the abuse, neglect or exploitation. Nursing facility must report all suspected or alleged incidents involving abuse, neglect, exploitation or mistreatment of resident property. A Nursing facility must report these incidents to the HHSC CII section.

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	675479	A. Building B. Wing	05/31/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20026 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 1 (Resident #58) of 12 residents reviewed for infection control; and 2 of 6 linen carts observed for infection control; 2 of 2 crash carts observed for infection control. The facility failed to ensure Resident #58's foley bag was not hanging from the trash can near the floor. The facility failed to keep linen cart covers in the laundry room free of tears. The facility failed to keep linen cart covers used to store clean linen free of stains. The facility failed to ensure staff were not storing clean eating utensils in linen cart. The facility failed to ensure linen carts were covered when left unattended in resident-use areas. The facility failed to keep 2 of 2 crash carts free of dust, paper particles, and dried stains This failure could place residents at risk for cross contamination and the spread of infection. Findings include: Laundry Room: Observation and interview on 05/31/24 at 10:09 AM, with laundry worker P and the Housekeeping/Laundry Supervisor revealed a linen container was covered with black plastic cover. It was observed that the black plastic linen cover had multiple linear tears directly above the elastic around the edges of the linen cover. Observation on 05/31/24 at 10:34 AM, with Housekeeping/Laundry supervisor in the East Side revealed, PVC Plastic Frame 4-Shelf linen cart stored in Zone 1, was covered with light blue cover that had multiple white stains on the cover. The Housekeeping/Laundry supervisor touched the stains with her ungloved hand and reported that it was lotion. She stated that the linen covers should be kept clean and free of stains. The second shelf was broken and held in place with a metal clothes hanger. The third shelf was broken and held in place with yellow duct tape. It was observed that multiple disposable briefs and four metal teaspoons were stored on the third shelf of the linen cart. Housekeeping/Laundry supervisor stated, staff should not be storing supplies in the clean linen carts, to prevent cross contamination. Zone 1 Linen Cart: (continued on next page)

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	675479	A. Building B. Wing	05/31/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 5/30/2024 at 2:23 PM, revealed a linen cart was uncovered and unattended in Zone 1 hall (Rooms 1 - 12). An unidentified resident was observed moving towels around in the uncovered linen cart. The cart contained gowns, blankets, towels gloves, briefs, sheets, and three open medication cups with white cream in them. In an interview on 05/30/24 at 2:27 PM, CNA Q revealed the linen cart should have the cover down when the cart was unattended. He said that residents should not have access to the clean linens because of possible contamination. In an interview on 05/31/2024 at 2:39 PM, the DON revealed that linen carts should be covered to reduce the risk of contamination of the clean linens. Crash Carts: Observation and interview on 05/28/24 at 10:06 AM, revealed with DON, the crash cart in the East Side had dust, small paper particles and dried stains on the first shelf where the suction machine was stored. DON stated licensed staff on the night shift were responsible for cleaning the cart when they checked the crash cart every night during their shift. Observation and interview on 05/28/24 at 10:08 AM, revealed with DON, the crash cart in the [NAME] Side had dust, small paper particles and dried stains on the first shelf where the suction machine was stored and the bottom shelf. DON stated licensed staff on the night shift were responsible for cleaning the cart when they checked the crash cart every night during their shift. Resident #58 Record Review of Resident #58's Face Sheet dated 05/31/2024 revealed he was [AGE] years old, admitted to the facility on [DATE]. Record review of Resident #58's history and physical dated 11/15/2023 he had a diagnoses of hypertension, type 2 diabetes mellitus, depression, and schizophrenia. Resident #58 had social issues being homeless and unable to take care of himself, also with psychiatric medical history and not being compliant with medications or plan of care. Resident #58 required nursing care around-the-clock. Record review of Resident #58's quarterly MDS assessment dated [DATE], revealed a BIMS score of 15 (cognitively intact). Resident #58 was diagnosed with hypertension (high blood pressure), type 2 diabetes mellitus, depression and schizophrenia (a disorder that affects a person's ability to think, feel and behave clearly). Record review of Resident #58's care plan dated 08/02/2023, revealed Resident #58 had Benign Prostatic Hypertrophy (enlarged prostate gland which can make or difficult or impossible for urine to flow) and is at risk of urinary retention. The care plan also revealed that Resident #58 had an indwelling catheter related to obstructive uropathy (blockage of urine flow). The care plan instructed to position the catheter bag and tubing below the level of the bladder and in a privacy bag. In observation on 05/29/24 at 01:24 p.m., Resident #58 was lying in bed and his catheter bag not covered by a privacy bag and it was hanging from the trash can near the floor. (continued on next page)

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	675479	A. Building B. Wing	05/31/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/29/24 at 01:24 p.m., Resident #58 revealed he did not know why the bag was not covered and why it was hanging on the trash can. Resident #58 said he knew that his urine bag is supposed to be hanging on the side of the bed, but he did not know why it was on the trash can. Resident #58 said that when he sits on his wheelchair, the urine bag is covered with a blue bag but that he did not know why it was not covered when he was lying down on his bed. Observation on 05/31/24 at 8:59 a.m., revealed that Resident #58 was sleeping on his bed and the catheter bag was hanging from the resident's side bed rail and that it was not covered with a privacy bag. In an interview on 05/31/24 10:10 a.m., LVN E revealed that catheter bags must be covered for privacy, even if the resident is in his room alone. She said that if the bag is not covered, it could create embarrassment for the resident because it violates his privacy. Upon observation of the picture taken on 05/29/24 at 1:24 PM, LVN E stated that it was not acceptable for the bag to be uncovered and hanging from the trash can. She said that there was a risk of infection for the bag hanging from the trash can. In an interview on 05/31/24 10:23 a.m., LVN B revealed that the foley bags need to be always covered, no matter if the resident is by himself in his room or if he's out in the common areas. Upon observing the picture taken on 05/29/24 at 1:24 PM, LVN B stated that the bag was not covered and that it should not be hanging from a trash can due to the risk of infections or contamination. In an interview on 05/31/24 11:50 a.m., the DON revealed that the catheter bag should be always covered to respect the resident's privacy and that it needs to be hung by the side rail of the bed to allow gravity to make the urine flow into the Foley bag. The DON observed the picture taken on 05/29/24 at 1:24 pm and stated that the way the bag was hanging on the trash can and not being covered was unacceptable. The DON said staff members such as LVNs and CNAs were expected to make rounds throughout their shifts to check on the residents assigned to their halls for privacy issues. The DON said that by the bag not being covered, it could result in Resident #58 feeling embarrassed since he is very vocal, and his cognitive level was high. The DON stated that there was a risk of infection because the bag was hanging from the trash can. Record review of the facility Resident Rights policy dated 11/28/16, revealed, Respect & Dignity - The resident has a right to be treated with respect and dignity. 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 and safety of other residents. Record review of the facility Catheter Care policy dated 2/13/07 revealed no specific information regarding infection prevention for catheters or foley bags placement. It stated: 10. Be sure the catheter tubing and drainage bag are kept off the floor.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20026 Based on observation, interview and record review the facility failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition for 1 of 1 kitchen reviewed for safe operating equipment; failed to maintain 1 of 6 linen carts in safe operating condition. The facility failed to maintain the oven in operational condition. The facility failed to maintain a working trash can next to the hand washing sink in the kitchen. The facility failed to correctly wash cookware using the three-compartment sink. The facility failed to maintain 1 of 6 clean linen carts in safe operating conditions. This failure could place residents at risk of foodborne illnesses; and potential for injury to residents and staff by not maintaining essential equipment in safe operating condition. Findings include: Observation and interview on 05/28/24 at 8:31 AM, the Dietary Manager revealed 3 of 5 stove knobs were missing. The oven door was being held closed by a bungie cord. The Dietary Manager stated that the hinges to the oven door were not working, and the oven would not stay closed. Interview with the Dietary Manager on 5/28/24 at 4:05 p.m., revealed that the oven in the kitchen had not been working for over a month and that the knobs of the stove had been missing for about 3 months. The Dietary Manager said, We turn on the stove with our fingers or with a towel. Observation and interview on 05/30/24 8:48 a.m., revealed the foot pedal of the trash can next to the handwashing sink in the kitchen was not working. Dietary Staff #1 assigned to dish washing stated, The trash can broke this morning. Observation 05/30/24 8:49 AM, with Dietary Staff #1 revealed she was assigned to dish washing. Dietary Staff #1 stated In the first sink we scrape the food from the pans and cookie sheets, rinse them off with water, place them in the second sink to wash the pans, then we place the pans in the third sink that contains the chlorine. After that we place the pans/cookie sheets in dish rack and run them through the dish washing machine to sanitize them. She stated she was not aware and did not know why they needed to check the chemical levels in the Three-Compartment sink. She stated, We only check the chlorine in the dish washing machine and document the results in the log that is kept on the wall by the dishwashing machine. She stated, she was not aware of the Three-Compartment Sink Procedures posted directly above the 3-compartment written in English and Spanish. Dietary Staff #1 could not recall if she had been trained in how to wash the pots and pans in the Three-Compartment-Sink. (continued on next page)

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	675479	A. Building B. Wing	05/31/2024

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview 05/30/24 8:54 AM, the Corporate Traveling Certified Dietary Manager and Dietary Staff #1, revealed that facility did not have logs to show that they were checking the chemical levels in the Three-Compartment Sink. The Consultant stated the facility only kept logs of the chemical checks done on the dish washing machine. Surveyor requested Policy & Procedure on using the Three-Compartment. Observation and interview 05/30/24 8:55 AM, the Traveling Certified Dietary Manager and Dietary Staff #1 revealed that staff will check the chemical levels after the washing cycle is completed. The test strip level was dark orange color 150 ppm. Interview 05/30/24 at 9:00 AM, with the Dietary Manager in the presence of the Corporate Traveling Certified Dietary Manager revealed that he had started working at the facility 4 days ago. He reported that he was aware that the kitchen staff were following the correct procedure on using the 3-compartment sink and had not had the opportunity to provide in-service training. He stated, I need to try to fix all identified concerns in the kitchen little by little. Interview on 05/30/24 at 9:03 AM, with Dietary Staff #2 assigned to wash dishes, in the presence of the Corporate Traveling Certified Dietary Manager and the Dietary Manager, reported that she had been employed at the facility for [AGE] years. She reported that she washes pots and pans in the Three-Compartment sink. She reported that in the first sink staff scraped the food from the pans and cookie sheets and rinsed them off with water, then we put them in the second sink to wash the pans, then we put them in the third sink that contains the chlorine. After that we put them on plastic rack and run them through the dish washing machine to sanitize them. She reported that they only checked the chemical level for the dish washer and kept a log when chemical levels were checked when they started to wash dishes. She could not remember when she was trained in how to use the 3-compartment sink. Review of poster posted directly above the Three-Compartment Sink revealed, Three-Compartment Sink Procedures. Dispenser to wash and sanitizer. 1. Wash Hot 110 degrees Fahrenheit. Fill the wash compartment with detergent solution. Wash lightly soiled items first-heavily soiled items last. Refill wash sink when suds dissipate. 2. Rinse all items in clean, hot water until all soap is removed. Change water often to prevent soap residue. 3. Fill sanitizer compartment with proper sanitizer solution. Completely immerse cleaned items in the sanitizer solution for at least one minute. Remove and place on clean surface to air dry. Check sanitizer solution frequently. Sanitizer Test Procedure: 1. Tear about 2 of test paper Hydrion QT-10. 2. Dip test paper in sanitizing solution for 10 seconds. Do not shake. 3. Compare strip to color chart on test paper dispenser at once. Test paper must read 150-400 ppm. Interview on 05/30/24 at 9:45 AM, with Corporate Traveling Certified Dietary Manager revealed that 1 of 2 ovens in the kitchen was not working. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 05/29/24 at 4:07 p.m., the Maintenance Supervisor revealed that the facility staff completed electronic work orders and send to him. He stated that one of the ovens in the kitchen had hinges that are not working properly, and the oven door does not close. The stove's temperature control valve was not working properly and does not regulate the temperature in the oven. He also reported the stove was missing the knobs to turn on the burners. He stated that the oven and stove issues have been going on for 2-3 months because the vendor had been having problems finding the parts. He stated that the parts for the oven and stove were ordered on Friday 05/24/24 and delivery were pending. I reported the issues with the oven and the stove to the administrator and she told me to fix them as soon as possible. Surveyor requested copy of Purchase Order and/or Invoice from Vendor. Interview on 05/30/24 at 9:32 AM, the Administrator revealed that she was aware that the hinges on the oven door had not been working for over a month. She stated that the oven door would not stay closed due to the hinges not working properly. She said she was not aware of any other issues with essential kitchen equipment. Administrator reported that the new Dietary Manager had started working May 23, 2024. She stated that the Dietary Supervisor had not reported any concerns to her. The administrator stated that she goes to the kitchen to check that Dietary staff are labeling foods and taking food temperatures. The administrator reported that they have an electronic system to submit work orders to the Maintenance Department. The staff will also verbally notify the Maintenance Director of any issues with equipment to ensure that work orders are promptly completed. The administrator reported that the area director had contacted a vendor to obtain the replacement parts for the oven door and that they are still pending delivery. The administrator stated that she was not aware that the oven hinges had not been working for several months. The Administrator was not aware that the stove knobs were missing from the stove. In a telephone interview on 05/30/24 at 9:52 a.m. the Dietitian revealed she started working at the facility on March 01, 2024. She said it was not part of her regular duties to conduct inspections of the kitchen during her monthly visits. She stated that she was not aware of any problems with equipment in the kitchen. She stated that if the dietary staff voiced any concerns during her visit, she would follow up on their concerns and conduct in-service training as needed. Record Review of Dietitian Consulting Contract dated March 01, 2024, revealed, Purpose: The purpose of this agreement is to arrange for dietetic consultation by the RD for the facility. Responsibilities of the Consultant: The RD's sole responsibility shall be to provide consultation to the facility. As such a consultant, the therapeutic dietitian shall give guidance and counsel the dietary department's food service program as follows: Oversees kitchen operation and provides consultation as necessary according to facility's policy. Participation of consultant on any survey for licensure or certification.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34486 Based on observation, interview and record review the facility failed to maintain an effective pest control program so that the facility is free of pests and rodents in one of six zones (Zone 1 Rooms 1 -12) reviewed for effective pest control. The facility failed to ensure that two live cockroaches were not found in Zone 1 (Rooms 1 -12) of the facility. This failure put residents at increased risk of transmission of vermin-borne illness. Findings include: Observation on 05/29/2024 at 11:09 AM, in room [ROOM NUMBER] revealed two large cockroaches (1.5 to 2 inches long) crawling on the floor. Surveyor R stepped on one of the roaches that was running quickly out of room [ROOM NUMBER] and into the hallway. In an interview and observation on 05/29/2024 at 11:12 AM, the Administrator came to room [ROOM NUMBER] and observed the live roach in room [ROOM NUMBER] and the dead roach in the hallway. She said that there should not be roaches in the facility because they were a contamination risk. She said the facility had a pest control program and would provide a copy of the contract and invoices showing when treatments were provided. In an interview on 5/29/24 at 11:19 AM, CNA S revealed that in a normal week she saw roaches every other day or two. She said she would go into the main shower and bathroom and sometimes would see them, dead or alive. She said if roaches were seen housekeeping would be called. She said she had seen people spraying for pests. Record review of the facility policy Insect and Rodent Control dated 2012 revealed that the facility would maintain an effective pest control program to provide an insect and vermin free food service department. Record review revealed the facility did have a contract with a local pest control provider and monthly invoices showed services were provided regularly.