

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675479	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2025
NAME OF PROVIDER OR SUPPLIER Franklin Heights Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. (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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<p>F 0559</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility to ensure resident's right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility was changed for 3 (Resident #13, Resident #57, and Resident #111) of four residents reviewed for notification of room change. 1-The facility failed to provide written notice of room transfer on 03/19/25 and 06/27/25 to Resident #13 or their Power of Attorney (POA), 5 days' notice must be given to the resident or responsible party prior to the move. 2-The facility failed to provide written notice of room transfer on 04/11/25 to Resident #57 or their Responsible Party, 5 days' notice must be given to the resident or responsible party prior to the move.3-The facility failed to provide written notice of room transfer on 04/13/25 and 04/22/25 to Resident #111, 5 days' notice must be given to the resident or responsible party prior to the move. These facility failures placed all residents at risk of being displaced without notice and/or reason in order to accommodate other individuals. 1-Record review of Resident #13's face sheet dated 07/22/25 revealed resident was a [AGE] year-old female with an admission date of 03/19/25. Face sheet revealed Resident #13 had a medical and financial POA. Record review of Resident #13's history and physical dated 04/22/25 revealed resident was legally blind and had medical history of physical debility (physical weakness, fatigue, or lack of energy that can impact daily functioning). Record review of Resident #13's quarterly MDS (Minimum Data Set) dated 06/22/25 revealed a BIMS (Brief Interview for Mental Status) score of 3, indicating severely impaired cognitive status. Record review of census per the facility's electronic charting system revealed Resident #13 was transferred to different rooms on 03/19/25 and on 06/27/25. Record review of Resident #13's progress notes dated 03/19/25 by LVN F revealed resident was admitted to the facility from a hospital and was verbally aggressive to the staff upon arrival. Progress notes did not notate Resident #13 requesting a room change, or that a room change occurred on 03/19/25, both rooms within Hall 4. Record review of Resident #13's progress notes dated 06/27/25 by LVN E called Responsible Party on 06/27/25 but there was no answer, and resident was transferred to another room on 03/19/25, from Hall 4 to Hall 2 on 06/27/25. There was no documentation of the reason for room transfer, or that resident was given notice. 2-Record review of Resident #57's face sheet dated 07/24/25 revealed a [AGE] year-old male with initial admission date 04/19/24 and re-admission date 06/25/25. Face sheet revealed Resident #57 had a Responsible Party. Record review of Resident #57's history and physical dated revealed medical diagnosis of hypertension (high blood pressure), severe anxiety, and Dementia with behavioral disturbances (Dementia is a decline of cognitive function that affects daily life, including memory, reasoning, and language skills). Record review of Resident #57's quarterly MDS dated [DATE] revealed a BIMS score of 12, indicating moderate cognitive impairment. Record Review of facility's Action Summary dated 07/24/25 revealed Resident #57 was transferred to different rooms within Hall 1 on 04/11/25. 3-Record review of Resident #111's face sheet dated 07/24/25 revealed a [AGE] year-old female with admission date 02/04/25. Face sheet revealed Resident #111 was her own Responsible Party. Record review of Resident #111's history and physical dated 02/06/25 revealed medical diagnosis of Hypertension (high blood pressure), Diabetes Mellitus II (a chronic disease when a person has persistently high blood sugar levels), Acute Kidney Injury (sudden decrease in kidney function that can lead to the accumulation of waste products in the blood), and chronic kidney disease (a long-term kidney disease causing gradual loss of kidney function affecting kidney's ability to filter waste and excess fluids from your blood). Record review of Resident #111's quarterly MDS dated [DATE] revealed a BIMS score of 12, indicating moderate cognitive impairment. Record review of facility's Action Summary dated 07/24/25 revealed Resident #111 was transferred on 04/13/25, both rooms within Hall 1, and 04/22/25, to Hall 4. In an interview on 07/21/25 at 09:45 AM with Resident #13 stated she had been transferred to different rooms twice and she stated she did not know the reason for the transfers. Phone call attempt made to Resident #13's POA, message and callback request left. POA had not returned call prior to exit. In an interview on 07/24/25 at 2:40 PM with Resident #111 stated she was not provided written notice for room transfer on 04/13/25, both rooms in Hall 1, and for room transfer on 04/22/25 to Hall 4. In an interview on 07/24/25 at 2:43 PM with Resident #57 stated he was not provided written notice for room transfer on 04/11/25, both rooms within Hall 1. In a telephone interview on 07/24/25 at 2:48 PM with Resident #57's Responsible Party (RP), who stated the RP was not provided a written notice of room transfer on 04/11/25. In an interview on 07/24/25 at 12:40 PM with the ADON who stated that Resident #13 was verbally aggressive to residents that are not English speaking</p>		

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<p>F 0574</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The resident has the right to receive notices in a format and a language he or she understands.</p> <p>(continued on next page)</p>		

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<p>F 0574</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on interview and record review the facility failed to ensure the residents had information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency and the State Long-Term Care Ombudsman program in a language understood for 7 of 7 residents (Confidential Group). The facility failed to ensure the Ombudsman information was reviewed with residents in the facility and ensure the information was discussed on how to file a complaint with the State agency when residents interviewed in a confidential group meeting were unaware, they had a Long-Term Care Ombudsman Program, contact information for the Ombudsman or how to file a complaint with the State agency. This failure could affect the residents who reside in the facility, to not be aware of resources that were available to them. Findings included: Record review of monthly resident council minutes for the last 6 months on 7/24/2025 at 8:40 am revealed no documentation of discussion regarding information on filing a complaint directly with the state agency or review of ombudsman information. In a confidential group meeting at 9:00 a.m., (7) residents present stated they did not know how to contact the ombudsman and how to file a complaint with the state agency. The residents agreed they were given a brief overview of the program and the name of the Ombudsman. During an interview with Administrator on 07/24/2024 at 3:30 p.m., revealed that upon admission the admission packet should have information regarding addressing concerns and grievance procedures. She stated that that when residents were admitted she introduced herself as administrator and as abuse coordinator and if residents or residents' families had any concerns, they could file a grievance directly with her, DON or any staff member that they voiced concerns with. She stated that she did not provide information verbally regarding filing complaints directly with the state, unless the family or resident voices that they do not wish to file the complaint with facility staff and wish to do it directly with the state, then the facility provides state number and ombudsman information. She stated that during resident council meetings the topic on state agency information was not discussed with residents as it was not a part of the checklist that corporate provides staff to use. During an interview with Activities Director on 7/24/2025 at 4:45 pm revealed that during resident council meetings, she goes through a checklist that touches on each department. She stated that if there were any concerns brought up during the meeting she was responsible for writing down the grievance and she has 3 to 5 days to resolve it. It was then brought up during the next meeting. She stated that the facility has ombudsman information posted in the entrance of the facility. She stated that residents and families could ask staff if they wanted the state number. She stated that the residents were verbally told that they had the right to file a complaint directly with the state if they wished to do so. She stated that she did not document that she verbally explained the process of contacting the state agency to file a complaint. Record Review of facility admission packet titled Health Care Center Policies, Information and Required Notices table of contents listed a section for policy for raising and addressing concerns grievance procedure, however, raising and addressing concerns grievance procedure section, was not covered in the facility packet and state agency number and ombudsman numbers were also not included. Record Review of resident rights policy revised on 11/28/2016 revealed The facility must provide a notice of rights and services to the resident prior to or upon admission and during the residents stay. The resident has the right to receive notices orally (meaning spoken) and in writing (including braille) in a format and a language he or she understands including, a list of names, addresses (mailing or email) and telephone numbers of all pertinent State regulatory and informational agencies. Resident advocacy group such as the State Survey Agency, the State licensure office, the state long term care ombudsman program, the protection and advocacy agency . A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding return to the community.</p>		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. (continued on next page)

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide ADL care for 3 of 16 residents (Resident #56, # 94 and #107) reviewed for ADLs.-The facility failed to ensure Resident #56, # 94 and #107's fingernails were clean and free from debris on 07/21/2025.-This failure could place residents at risk of not having their personal hygiene needs met and cause low self-esteem.The findings include: Record review of Resident # 56's admission Record dated 7/23/2025 revealed a [AGE] year-old male with an initial admission date of 07/20/2020 and a readmission date of 08/19/2024. Record review of Resident # 56's health and physical dated 06/20/2025 revealed medical diagnosis of vascular dementia unspecified severity Record review of Resident # 56's quarterly MDS assessment dated [DATE] revealed a BIMS of 03 indicating severe cognitive impairment. Record review of Resident # 56's care plan dated 07/08/2025 revealed the resident had an ADL selfcare performance deficit related to muscle weakness, debility and unsteady gait/mobility and required 1 staff participation with personal hygiene and oral care. In an observation of Resident #56 on 07/21/2025 at 9:10am, the resident in the room was lying in bed. Some of his fingernails were observed to be long or chipped on hands bilaterally. Record review of Resident #94's admission Record dated 07/23/2025 revealed resident was a [AGE] year-old female with an initial admission date of 07/08/2022 and a readmission date of 07/26/2022. Record review of Resident #94's health and physical dated 08/01/2024 revealed medical diagnosis of Huntington's disease (inherited brain disorder that causes involuntary movements, cognitive decline and behavioral changes). Record review of Resident #94's quarterly assessment MDS dated [DATE] revealed BIMS of 06 indicating severe cognitive impairment. Record review of Resident #94's care plan dated 07/26/2025 revealed resident had an ADL self-care performance deficit calling for one staff participation with personal hygiene and oral care. In an observation and interview with Resident #94 on 07/21/2025 at 9:30 am, revealed resident with long dirty fingernails on both hands. She stated that staff did not cut them and that she would like them to cut them for her. Record review of Resident #107's face sheet dated 07/22/25 revealed resident was a[AGE] year-old male with an initial admission date 07/07/25. Record review of Resident #107's health and physical dated 07/07/25 revealed medical diagnosis of Unspecified Dementia with unspecified severity without behavioral disturbance, Diabetes Mellitus, hemiplegia (a condition characterized by severe or complete paralysis on one side of the body. This means a significant or total loss of muscle strength and control in the arm, leg, and sometimes the face on either the left or right side) and hemiparesis (a condition characterized by weakness or partial loss of strength on one side of the body) lack of coordination and inability to perform activities of daily living. Record review of Resident #107's admission MDS dated [DATE] revealed a BIMS score of 9 indicating moderate cognitive impairment. Section GG-Functional Abilities notated Resident #107 required substantial/maximal assistance and was dependent, meaning the helper does more than half or all the effort to complete activities.Record review of Resident #107's care plan revealed he had an ADL self-care performance deficit and called for staff to assist as needed with grooming, bathing, and personal hygiene. Interventions during bathing called to check for nail length and to trim and clean on bath day as necessary. In an observation and interview on 7/21/25 at 3:13 PM with Resident #107, revealed he was found lying in bed, watching TV, and eating cookies using his right hand. It was observed that he had long, yellowish fingernails with dirt and debris underneath them. Resident #107 stated that he was paralyzed from the left side of his body and could not move his arm, hand, leg, or feet. When asked if he preferred to have long fingernails, he stated he did not and had previously requested staff assistance to trim his nails several times, but no one had helped him.In an interview on 7/23/25 at 11:19 AM with CNA A, who stated the CNAs were able to assist residents with trimming their fingernails if they were not diabetic. She also stated that RNs and LVNs were able to assist residents if they observed them with long fingernails, and that it was all the staff's responsibility to check the resident's fingernails. CNA A said that if they detected a resident had long fingernails, they needed to report it to the charge nurse and then assist the resident with trimming the fingernails. CNA A stated the risk for a resident not having fingernails trimmed was that they could scratch themselves and open a wound which would lead to infection and make the resident sick.In an interview on 7/23/25 at 11:27 AM with LVN B, who stated that the nurses were responsible for assisting the residents with nail trimming. He stated that CNAs had more contact with the residents and were responsible for monitoring their hygiene in general and making sure their nails were trimmed. LVN B stated the risk for a resident having long and dirty</p>		

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<p>F 0755</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>The findings included:An observation and interview on 07/23/25 at 11:55 AM with Treatment LVN, revealed red dried drippings on the Betadine bottle stored in the treatment cart. Treatment LVN stated all bottles should be clean and free of dried drippings. He stated dried drippings were an infection control issue which can affect the residents. Treatment LVN stated he was responsible for the maintenance of the treatment cart. An interview on 07/24/25 at 12:25 PM with the ADON who stated the Treatment LVN was responsible for the treatment cart. She stated the Treatment LVN were to review their treatment cart daily for cleanliness including bottles being free from dried drippings. The ADON stated it was her and the DON's responsibility to monitor all carts for cleanliness on a weekly basis. The ADON stated the risk for dried drippings on the Betadine bottle included an infection control issue which was a risk for the residents being treated.An interview on 07/24/25 at 1:16 PM with the DON who stated that the Betadine bottle should be clean. The DON stated she was also the Infection Preventionist. She stated dried drippings were potential for bacteria accumulation which can cause the bottle to be contaminated. The DON stated the Treatment LVN was responsible for the cleanliness of their Betadine bottle stored in the treatment cart. She stated the Treatment LVN was to monitor their treatment cart daily throughout their shift while providing treatment. She stated herself and the ADON were responsible for monitoring all carts every 2 weeks.Record Review of policy Medication Carts, with no date, read in part: The medication carts shall be maintained by the facility, carts should be cleaned.The findings included:An observation and interview on 07/23/25 at 11:55 AM with Treatment LVN, revealed red dried drippings on the Betadine bottle stored in the treatment cart. Treatment LVN stated all bottles should be clean and free of dried drippings. He stated dried drippings were an infection control issue which can affect the residents. Treatment LVN stated he was responsible for the maintenance of the treatment cart.An interview on 07/24/25 at 12:25 PM with the ADON who stated the Treatment LVN was responsible for the treatment cart. She stated the Treatment LVN were to review their treatment cart daily for cleanliness including bottles being free from dried drippings. The ADON stated it was her and the DON's responsibility to monitor all carts for cleanliness on a weekly basis. The ADON stated the risk for dried drippings on the Betadine bottle included an infection control issue which was a risk for the residents being treated.An interview on 07/24/25 at 1:16 PM with the DON who stated that the Betadine bottle should be clean. The DON stated she was also the Infection Preventionist. She stated dried drippings were potential for bacteria accumulation which can cause the bottle to be contaminated. The DON stated the Treatment LVN was responsible for the cleanliness of their Betadine bottle stored in the treatment cart. She stated the Treatment LVN was to monitor their treatment cart daily throughout their shift while providing treatment. She stated herself and the ADON were responsible for monitoring all carts every 2 weeks.Record Review of policy Medication Carts, with no date, read in part: The medication carts shall be maintained by the facility, carts should be cleaned.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, 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. -The facility failed on 07/21/2025 to seal a container with marinara sauce inside of refrigerator #1. -The facility failed on 07/21/2025 to maintain 1 strawberry ice cream container free from drippings in refrigerator # 3.-The facility failed on 07/21/2025 to close or seal a bag containing frozen egg omelets inside of refrigerator #4. -The facility failed on 07/21/2025 to dispose of rotting and moldy onions and potatoes in the pantry. These failures could place all residents who received meals from the main kitchen at risk of food borne illnesses. During observations on 07/21/2025 at 8:21 AM inside refrigerator #1, a container with marinara sauce was found not properly sealed with the lid not properly closed. At 8:23 AM, a tub of ice-cream was found inside refrigerator #3 that had dried and frozen drippings on its sides. At 8:29 AM a box with frozen egg omelets was found inside refrigerator #4. The box and the bag containing the frozen egg omelets was open and not sealed. At 8:32 AM, two rotten and moldy onions were found in the container with the rest of the fresh onions. At 8:33 AM, two moldy potatoes were found inside the box with the fresh potatoes. In an interview on 07/23/2025 at 8:21 AM with the Director of Food and Nutrition, stated that cooks were responsible for checking the pantries and fridges to ensure everything was clean, sealed, and free of rotting food. She explained the facility had a system in place where, at the end of their shifts, breakfast and evening cooks were required to check for spoiled or expired items and ensure everything was clean and sealed. The Director of Food and Nutrition said if an issue was found, it was expected for them to correct it by disposing the expired food. She said this was part of their cleaning duties worksheet, and they were required to check off that everything was clean. The Director of Food and Nutrition said staff would have been expected to conduct their daily checks on 7/20/25 after the evening shift was done. The Director of Food and Nutrition stated there was a potential risk of cross-contamination from open containers inside the refrigerator, bacteria and attracting pests from dry drippings, and rotten and moldy vegetables could contaminate other food and vegetables, potentially making residents sick. She stated that rotting vegetables could also potentially attract insects such as flies and cockroaches. In an interview on 07/23/2025 at 10:15 AM with the Dietary Supervisor who stated that everyone in the kitchen was responsible for checking that the food was dated, sealed, and containers inside the refrigerator were clean. The Dietary Supervisor said that it was her and the Director of Food and Nutrition's responsibility to check all recipients inside the refrigerators to ensure they were clean and sealed, and to dispose of any expired items or rotting and moldy vegetables. The Dietary Supervisor said she believed the facility did not have a system to track who was checking the refrigerators for cleanliness or for checking the pantries for expired or rotting food. The Dietary Supervisor stated that the risk for not properly sealing, closing, and cleaning containers inside the refrigerators when food was stored could result in cross-contamination and residents getting sick and there was also the possibility that they could attract pest such as insects. She stated that rotting food such as vegetables could create bacteria, spoil the rest of the vegetables, and potentially make residents sick if staff were to cook a meal with spoiled vegetables. In an interview on 07/23/2025 at 10:30 AM with a Dietary Cook, who stated that all staff were responsible for checking if containers were sealed and free of spills and drippings. If spills or drippings were present, staff needed to clean them, as the potential outcome was attracting insects, and serving food from unsealed containers could make residents sick. The cook also stated that the potential risk of having rotten vegetables mixed with other vegetables was for them to spoil the rest, and if food was prepared with rotten vegetables, there was a risk of making residents sick. In an interview on 7/24/25 at 3:32 PM, the Administrator stated that the kitchen staff had a cleaning list with tasks they were supposed to complete at the end of their shift. She said staff were trained annually through their computer system in everything related to cleaning and disinfecting the kitchen. The administrator said the Director of Food and Nutrition would be the person responsible for making rounds in the kitchen, ensuring there were no spoiled vegetables or expired food, and instructing staff to clean any containers that had dry drippings of food residues. She stated that the potential risk of having spoiled vegetables and open food containers could result in cross-contamination, which could make the residents sick. The administrator said that spoiled vegetables could create bacteria that would spoil other vegetables and could also potentially attract insects like roaches or flies, which carry diseases that could contaminate other foods and make the residents sick. Record Review of the form titled INAME1 Heights</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>(continued on next page)</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to have complete and accurately documented medical records for two (Resident #13 and #111) of five residents whose clinical records were reviewed for accuracy.-The facility failed to document room transfers and the reason for transfers for Resident #13 on 03/19/25 (Hall 4) and 06/27/25 (Hall 4 to Hall 1).-The facility failed to document room transfer and the reason for transfer for Resident #111's on 04/13/25 and 04/22/25. These failures could affect the residents in the facility at risk of inaccurate or incomplete clinical records. Findings included:Resident #13Record review of Resident #13's face sheet dated 07/22/25 revealed resident was a [AGE] year-old female with an admission date of 03/19/25.Record review of Resident #13's history and physical dated 04/22/25 revealed resident was legally blind and had medical history of physical debility (physical weakness, fatigue, or lack of energy that can impact daily functioning).Record review of Resident #13's quarterly MDS (Minimum Data Set) dated 06/22/25 revealed a BIMS (Brief Interview for Mental Status) score of 3, indicating severely impaired cognitive status. Record review of census per the facility's electronic charting system revealed Resident #13 was transferred to different rooms on 03/19/25 and on 06/27/25.Record review of Resident #13's progress notes dated 03/19/25 by LVN F revealed resident was admitted to the facility from a hospital and was verbally aggressive to the staff upon arrival. Progress notes did not notate verbal aggression to her roommate, Resident #13 requesting a room change, or that a room change occurred on 03/19/25, both rooms within Hall 4. Record review of Resident #13's progress notes dated 06/27/25 by LVN E called Responsible Party on 06/27/25 but there was no answer, and resident was transferred to another room, from Hall 4 to Hall 2. There was no documentation of the reason for room transfer, or that resident was given notice.Resident #111Record review of Resident #111's face sheet dated 07/24/25 revealed a [AGE] year-old female with admission date 02/04/25.Record review of Resident #111's history and physical dated 02/06/25 revealed medical diagnosis of Hypertension (high blood pressure), Diabetes Mellitus II (a chronic disease when a person has persistently high blood sugar levels), Acute Kidney Injury (sudden decrease in kidney function that can lead to the accumulation of waste products in the blood), and chronic kidney disease (a long-term kidney disease causing gradual loss of kidney function affecting kidney's ability to filter waste and excess fluids from your blood).Record review of Resident #111's quarterly MDS dated [DATE] revealed a BIMS score of 12, indicating moderate cognitive impairment.In an interview on 07/21/25 at 9:45 AM with Resident #13 who stated she had been transferred to different rooms twice and she stated she did not know the reason for the transfers.In an interview on 07/24/25 at 2:40 PM with Resident #111 who stated he transferred rooms on 04/13/25, both rooms in Hall 1, and transferred rooms on 04/22/25 to Hall 4.In an interview on 07/24/25 at 12:40 PM with the ADON who stated that Resident #13 was verbally aggressive to staff and residents that are not English speaking. She stated Resident #13 was transferred rooms on 03/19/25 because her roommate was not comfortable with Resident #13 since the roommate was primarily Spanish speaking. She stated Resident #13 was transferred rooms on 06/27/25 since resident was a skilled nursing resident and changed to a long-term resident. The ADON stated the CNA's, and Nurses were responsible for their progress notes ensuring accurate documentation. She stated herself and the DON were responsible for monitoring documentation on a daily basis.In an interview on 07/24/25 at 1:18 PM with the DON, who stated Resident #13 was transferred to another room on 03/19/25 because of aggression to her initial roommate. The DON stated Resident #13 transferred rooms on 06/27/25 because she became a long-term resident. She stated the nurse's progress notes did not reflect the room change on 03/19/25 and did not reflect Resident #13's request for the room transfers that day. She stated it should have been documented, and accurate documentation was the responsibility of the nurse adding the progress note. She stated herself and the ADON monitor progress notes for accuracy daily. She stated the lack of documentation was a risk for inaccurate treatment of the resident because behaviors or trends are not documented. In an interview on 07/24/25 at 3:15 PM with the Administrator who stated Resident #13 was transferred on 03/19/25 because Resident #13 was upset her roommate in Hall 4 spoke primarily Spanish. She stated Resident #13 was transferred to another room in Hall 4 that day she was admitted [DATE]. The administrator stated the reasoning for the transfers on 03/19/25 and 06/27/25, should have been documented by the nurses. The Administrator stated she reviewed Resident #13's progress notes and did not observe any notation regarding reason for room change for both mentioned dates. She stated the ADON and DON were responsible for</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675479	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2025
NAME OF PROVIDER OR SUPPLIER Franklin Heights Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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.

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675479	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2025
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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an effective pest control program so that the facility was free of pests and rodents for 1 of 1 kitchen. -The facility failed on 07/21/2025 to effectively remain free of cockroaches in the only kitchen in the facility. These findings placed residents at risk of ill effects of pest infestation. During observation and interview on 07/21/2025 at 8:15 AM with the Director of Food and Nutrition, two dead cockroaches were observed on the kitchen floor in between cooking stations near a water drain. They were in near proximity to cooking utensils, pots and pans. The Director of Food and Nutrition stated that it was likely that cockroaches were present in the kitchen because it had been raining in the area and that made the insects crawl into the kitchen. The Director of Food and Nutrition stated that she would direct her staff to immediately clean and disinfect the kitchen floors. She stated the potential outcome of having insects in the kitchen could result in cross contamination which could lead to residents getting sick if the insect were in contact with food or the utensils used to prepare their meals. Record Review of the form titled [NAME] Heights Cleaning Duties from July 20, 2025, to July 26, 2025, revealed the form had been initialed only by one staff member from the evening shift, indicating the blender, mixer and back wall had been cleaned. The form did not have times nor any other initials or information from other staff members. In an interview on 07/23/2025 at 10:15 AM with the Dietary Supervisor who stated she had seen cockroaches before in the kitchen but as of late, due to the rain, she had seen cockroaches more frequently. She stated whenever she had seen roaches, she reported it to her supervisor or to the administrator. The Dietary Supervisor said she believed her supervisor had called pest control on Monday 7/21/25 for them to spray insecticide in the kitchen. The Dietary Supervisor said the expectation was for staff to sweep, mop, and disinfect twice in the morning and once in the evening or as required if the floor looked dirty. The Dietary Supervisor stated it was her and her supervisor's responsibility for checking that staff were cleaning and disinfecting the kitchen properly. She stated the risk of having insects such as cockroaches in the kitchen could result in cross-contamination and residents could get sick because their defenses were low. In an interview on 07/23/2025 at 10:30 AM with a Dietary [NAME] who stated staff were supposed to clean, sweep, and mop as needed if the floors were dirty and before they left their shift. The Dietary cook admitted she had not been signing off the Cleaning Duties sheet, because she got busy with other tasks such as preparing food for the residents. She stated the potential outcome of having insects in the kitchen could result in food being contaminated and making the residents sick. In an interview on 7/24/25 at 1:22 PM with the DON who stated she was the appointed Infection Control Preventionist for the facility. She stated that the facility had a contract with a company for pest control, and they went to the facility monthly to spray insecticides to prevent plagues and insects which could get the residents sick. The DON stated staff in the kitchen were expected to clean the kitchen every day at the end of their shift and as needed if there was a spill or something was dirty or became contaminated. She explained that cleaning entailed sweeping, mopping, and disinfecting the floors, making sure there were no food residues or crumbs on the floor, pantries, or refrigerators. The DON said staff were expected and instructed to report any presence of insects to their immediate supervisor, the administration, or herself. The DON stated that if staff found cockroaches in the kitchen, it was expected for them to immediately clean and disinfect the area. The DON said there was a potential negative outcome of residents getting sick if they consumed food that had been contaminated by insects such as cockroaches, and they could get gastrointestinal infections making them sick. In an interview on 7/24/25 at 3:32 PM, the Administrator who stated kitchen staff were expected to clean the kitchen at the end of every shift and as needed. The Administrator said the expectation was for staff to immediately clean and disinfect the area if they found dead insects such as cockroaches to prevent the spread of infection or cross contamination. The administrator said that staff needed to report any findings of insects or rodents to their supervisor immediately so that the pest control company could be contacted for them to service the facility and prevent residents' widespread sickness. She stated that the potential risk of cooking meals for the residents while insects were present in the kitchen could result in cross-contamination, which could make the residents sick. Record Review of the facilities policy dated 2012, titled Dietary Services Policy and Procedure Manual: Food Storage and Supplies, read in part: All facility storage areas will be maintained in an orderly manner that preserves the condition of food and supplies. We will ensure storage areas are clean, organized, dry and protected from vermin and insects. Insect and Rodent Control ? Facility will maintain appropriate screens</p>		