

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675897	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2025
NAME OF PROVIDER OR SUPPLIER Franklin Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 700 Hearne St Franklin, TX 77856	
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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to ensure that residents received housekeeping services to maintain a sanitary and comfortable interior for 1 of 8 residents (Resident #22). The facility failed to ensure that housekeeping attendants cleaned and sanitized the interior of the bathroom cabinet in Resident #22's bathroom. This failure could result in potential cross contamination and illness for residents. Findings included: Record review of Resident #22's undated face sheet, printed on 9/09/2025, reflected a [AGE] year old female admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease (a lung disease limiting air flow from the lungs), cognitive communication deficit (problem with communication caused by cognition rather than a language or speech deficit), and paranoid schizophrenia (condition in which the mind creates a highly detailed alternate reality that feels completely real, causing suspicion and fear). Record review of Resident #22's quarterly MDS, dated [DATE], reflected a BIMS score of 9 (moderate cognitive impairment). Record review of Resident #22's care plan reflected a Focus Area indicating, [Resident #22] has an ADL Self Care Performance Deficit at times r/t Schizophrenia, depression and dementia. Date Initiated: 01/07/2014 with a related intervention of , TOILETING: the resident is independent and continent of bowel and bladder. Date Initiated: 01/07/2014. Revision on: 12/10/2014. During an observation and interview on 9/09/2025 at 09:54 AM, Resident #22, stated there were roaches in the bathroom. She stated the facility has treated for roaches. She stated there was evidence of the roaches in the bathroom cabinet. The bathroom was observed to be clean with no evidence of pests. An observation of the inside of the bathroom cabinet in Resident #22's room revealed a collection of a dry, black substance scattered on the inside of the cabinet and the wall inside the cabinet. She stated the black substance in the cabinet was roach excrement. During an observation of Resident #22's bathroom on 9/10/2025 at 11:47AM, revealed a clean bathroom with a collection of a dry, black substance scattered on the inside of the cabinet and the wall inside the cabinet. There was no observable change to the soiled areas inside the cabinet from the previous day. Resident #22's room was observed to be clean with no evidence of pests. During an interview on 9/10/2025 at 12:11PM, Resident #22 stated she had not told the facility about the suspected roach excrement in the bathroom cabinet. She stated she thought they would just fix it, but they had not. During an interview and observation with Housekeeper B on 9/10/2025 at 1:03PM, he stated he believed Resident #22 was the only room with a bathroom cabinet He stated he mostly cleaned the floors and had not cleaned Resident #22's bathroom in a long time. He stated the other housekeeper on staff would have cleaned that room, but she was on break He stated the housekeeping department does deep cleaning of resident rooms on a rotation. He stated he thinks Resident #22 was due for a deep cleaning soon. During an observation of Resident #22's cabinet, Housekeeper B stated, That's not good. That is roach feces. He stated he was not sure why the inside of the cabinet was not cleaned. He stated he would clean it right away. He stated the risk to the resident of not cleaning her environment adequately was she could become very sick. In an interview on 9/10/2025 at 1:11 PM with the Housekeeping Director, she stated she thought the black substance in Resident #22's cabinet (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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She stated that there is a monthly deep cleaning done for all resident rooms. She stated that she believed that Resident #22 was due to be cleaned for the month. She stated she sent out daily messages to staff after the morning meeting regarding any known areas of concern for the building. She stated a portion of the roof of the building was blown off in a storm recently and the facility was working to treat for any pests and repair any holes that were noted during inspection by the staff or pest control. She stated that since that time there had been reports of roaches in the facility, but the staff had been in regular communication with pest control services to treat regularly monitor the building for any new access points for pests or vermin. She stated she had observed large roaches, but had not seen any rodents. She stated she did not know if the housekeeper checked the cabinet to see the black substance inside. She stated that staff probably know that the inside of the cabinet is not in use. She stated that the department does a deep clean once a month for all resident rooms. She stated she expected staff to look inside the cabinet when they were cleaning the bathroom. She stated she expected housekeeping staff to look under, over, and through things as they are cleaning. She stated she would make a note to herself to check the cabinet daily and ensure it was cleaned in the future. She stated she would add that room number to the list of rooms for the Pest Control Technician to look at when he visited. She stated she would do an in-service right away to alert staff to the issue. During an interview on 9/10/2025 at 1:23 PM, the DON stated, I don't know why she has a cabinet. They probably don't think to clean it because there are no other cabinets. She stated that she expected the bathrooms to be cleaned daily, including the bathroom cabinet for Resident #22. She stated she would add it to the morning rounds and discuss it during the morning meeting in the future. She stated pest control had been in the facility that morning on 9/10/2025. She stated she was not aware of black substance scattered in the bathroom cabinet for Resident #22. She stated that, If [Resident #22] touched it, she could get an infection. She stated the facility called pest control yesterday to treat for flies. She stated that anytime the [pest control technician] was in the facility, the staff would tell him any areas to focus on or where insects were seen. She stated that the facility was working to declutter trash and unwanted personal items for residents in addition to their pest control visits to minimize opportunities for food and housing of pests and/or vermin. In a telephone interview on 9/10/2025 at 2:07PM, the Pest Control Technician stated it was probably roach feces in the bathroom cabinet from the description, but that he could not be sure. He stated he has been coming more than monthly to the facility. He stated they had more problems since the incident with the portion of the roof was damaged recently and being an older building in the country was challenging. He stated that he primarily treated for flies and was monitoring for signs of vermin in the kitchen area and possible entry points for pests and vermin into the building on 9/10/2025. He said he felt the facility was staying on top of their communication with him and trying to keep things under control. He stated the pest situation at the facility was definitely improving. He stated he had not see the bathroom cabinet when he was in the facility earlier that day. He stated he did not treat that room for roaches or inspect it during the visit on 9/10/2025. He stated he was not aware there was a continued problem in that resident room specifically. In an interview on 9/11/2025 at 10:04 AM with RNC, she stated housekeeping should be cleaning the bathrooms daily. She stated pest control was out more than monthly lately. She stated she felt like the facility was doing everything they could to (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	manage pests inthe building. She stated the condition of the cabinet for Resident #22's bathroom was not an acceptable level of cleanliness. She stated that the potential risk to the resident if they got into the cabinet was it could cause some sort of illness. During an interview on 9/11/2025 at 11:05 AM, the ADMIN stated he ensured they deep cleaned Resident #22's room after the cabinet was brought to the attention of the housekeeper by surveyor on 9/10/2025. He stated the facility planned to remove the cabinet in her room and install a sink like the other rooms in the facility. He stated he was not aware the inside of the cabinet for Resident #22 was soiled. He stated the bathroom should be cleaned daily by housekeeping. He stated that he would have the staff check the cabinet in the future during morning rounds. He stated that even though it is the only bathroom cabinet in the facility, it was expected that it should be cleaned and decluttered. He stated that from the look of the cabinet and knowing the history of the building, he thought the black substance was roach related. He stated that the effect on the resident of having a unclean bathroom would be that it could contribute to contamination or illness for the resident. Record review of Service Inspection Report from Pest Control Technician visit dated 9/01/2025, reflected, The medical records office. She mentioned seeing some American cockroaches in [Resident #22's room]. Resident was unable to be moved. I did find 3 live American cockroaches in the closet and bathroom. These cockroaches were disposed of. Resident was unable to be moved. Bait and monitors were applied. As I pulled up to the facility. The first thing I noticed was the missing roof. This facility has lost half of the roof over the 400 hallway, from a storm that hit about 2 weeks ago. The old damaged roof is still there.,but the tin has blown off.I checked in with the [Maintenance Director] and he said that he didn't know of any issues. The dietary staff said that they had been doing good. They hadn't seen anymore rodent activity, since I was there last. A liquid spot residual was applied to the kitchen, dining room,common areas, offices, nurses station,entranceways, and exits. The fly light glue boards were replaced. Record review of facility policy printed on 9/11/2025 at 11:54PM for Resident Rights (undated) reflected: The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this policy.A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure that the comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment for 2 (Resident #9 and Resident #37) of 6 residents reviewed for care plans. The facility failed to update Resident #9's and Resident #37's care plan to reflect current activity needs for in room activities. This failure could place residents at risk for not receiving necessary services or having important needs identified and met. Findings included:Record review of Resident #9's face sheet, dated 09/10/2025, reflected a [AGE] year-old male, admitted [DATE] and readmitted [DATE]. Resident #9 had diagnoses which included major depressive disorder, unspecified (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety disorder (a mental health disorder that produces fear, worry, and a constant feeling of being overwhelmed), other lack of coordination (the body's movements are not smooth, controlled, or precise resulting in unsteadiness, and difficulty with everyday tasks) and unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (a condition where individuals experience cognitive decline consistent memory loss, impaired thinking, etc . without behaviors).Record review of Resident #9's annual MDS Assessment, dated 06/16/2025, reflected Resident #9 had a BIMS score of 5, indicating severely impaired cognition. -Further review reflected Resident #9 indicated going outside to get fresh air was very important to him. The following activities was somewhat important such as reading books, being around pets, listening to music, keeping up with the news, and doing favorite activities. Record review of Resident #9's Comprehensive Care Plan, dated 07/20/2025, reflected no revisions of activity preferences and needs assessed in August 2025. Resident #9 was identified first week of August as needing in room activities 2-3 times per week related to a decline in attending group activities. Record review of Activity in Room Resident List, not dated, on 09/09/2025 reflected Resident #9's name was on the list to receive in room activities 2 to 3 times per week. During an observation and interview on 09/09/2025 at 10:50 AM, Resident #9 was lying in bed staring at the wall in front of him. His television was not on in his room. Resident #9 was not interviewable . Record review of Resident #37's face sheet, dated 09/10/2025, reflected a [AGE] year-old male, admitted on [DATE]. Resident #37 had diagnoses which included unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (a condition where individuals experience cognitive decline consistent memory loss, impaired thinking, etc . without behaviors), legal blindness, as defined in USA (an eye which has limitation in the field of vision so that the widest diameter of the visual field was at an angle no greater than 20 degrees was considered to have a central visual acuity of 20/200 or less), age-related nuclear cataract, bilateral (clouding or hardening of the central part of the eye's lens of both eyes), and primary osteoarthritis in right and left shoulder (a degenerative condition where the protective cartilage in the shoulder joint wears away, leading to bones rubbing against each other, causing pain, stiffness, and loss of motion). Record review of Resident # 37's Annual MDS Assessment, dated 02/09/2025, reflected Resident #37 had a BIMS score of 5, which indicated his cognition was severely impaired. Further review reflected Resident #37 indicated listening to music was very important to him with the following activities were somewhat important: being around pets, I keeping up with the news, and doing favorite activities. Record review of Resident#37's Quarterly MDS Assessment, dated 08/29/2025, reflected Resident #37 had a BIMS score of 3, which indicated his cognition was severely impaired. Record review of Resident #37's Comprehensive Care Plan, reflected Resident #37 (date initiated on 05/13/2024) had little or no activity involvement related to resident wishes not to participate. Resident #37 would participate in activities of choice 2 to 3 times per week. An intervention was to explain to the resident the importance of social interaction, leisure activity time, and encourage the resident's participation. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident risk for weight loss. Intervention: Encourage food related activities. Record review of Activity in Room Resident List, not dated, on 09/09/2025 reflected Resident #37's name was on the list to receive in room activities 2 to 3 times per week. Interview on 09/11/2025 at 9:05 AM MDS Coordinator stated any time there was a change in a resident's physical condition, cognition, or activity preferences. The residents care plan was expected to be revised to reflect any changes with the resident. She stated if a resident needed in room activities after the comprehensive care plan was completed, the Activity Director was expected to revise the activity care plan and inform the IDT of the changes. She stated the Activity Director had opportunity to inform the IDT in morning meetings. The MDS Coordinator stated any residents in the facility she was not aware of any changes in their activity level or preferences. Interview on 09/11/2025 at 9:40 AM, the Activity Director stated Resident # 9's and Resident #37's care plans were not revised in August 2025 to reflect their changes in activity needs such as being provided in room activities. She stated anytime a resident's activity preference or activity abilities changed; the residents care plan was expected to be revised to reflect these changes. She stated if a resident was having behaviors or was depressed and staff reviewed the care plan; the staff would not know the accurate activities interventions to provide for the resident. She stated she had been in-serviced on care plans but did not recall the date. She stated she did not recall why the care plan was not revised. Interview on 09/11/2025 at 10:00 AM, the Assistant Director of Nurses stated all care plans was expected to be revised anytime there was a change of physical condition, mental status, or activity preferences. She stated if a resident activity level changed and needed different type of activities, such as in room activities, the residents care plan was expected to be revised to reflect resident activity needs and preferences. She stated the care plan was a tool the staff used to know how to treat a resident's physical needs, cognitive needs, interventions of any type of behaviors, activity preferences, etc. She stated a care plan could be revised at any time. She stated if there were any changes in activity level or activity preferences with a resident the Activity Director was expected to revise the care plan to reflect their current activity needs. Record review of the Facility's Comprehensive Care Planning, not dated, reflected Residents' preferences and goals may change throughout their stay, so facilities should have ongoing discussions with the resident and resident representative, if applicable, so that changes can be reflected in the comprehensive care plan.		

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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** Based on observations, interview and record review, the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for two of eight residents (Resident# 9, and Resident #37) reviewed for ADL care. The facility failed to ensure Resident #9's and Resident # 37's nails were cleaned, and did not have any rough edges. This failure could place residents at risk of not receiving services or care, diminished quality of life, and decreased self-esteem. Findings included: Record review of Resident #9's face sheet, dated 09/10/2025, reflected a [AGE] year-old male, admitted [DATE] and readmitted [DATE]. Resident #9 had diagnoses which included major depressive disorder, unspecified (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety disorder (a mental health disorder that produces fear, worry, and a constant feeling of being overwhelmed), other lack of coordination (the body's movements are not smooth, controlled, or precise resulting in unsteadiness, and difficulty with everyday tasks) and unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (a condition where individuals experience cognitive decline consistent memory loss, impaired thinking, etc . without behaviors). Record review of Resident#9's Annual MDS Assessment, dated 06/16/2025, reflected Resident #9 had a BIMS score of 5, which indicated his cognition was severely impaired. Resident #9 required partial/moderate assistance - helper does more than half the effort with the following: personal hygiene, upper body dressing, and oral hygiene. He required substantial/maximal assistance - helper does more than half the effort with the following: lower body dressing, showers, and putting on/taking off footwear. Record review of Resident #9's Comprehensive Care Plan, dated 07/20/2025, reflected Resident #9 had an ADL self-care performance deficit. Interventions: Resident #9 required assistance with personal hygiene and bathing. Check nail length and trim and clean on bath day and as needed. Report any changes to the nurse. During an observation and interview on 09/09/2025 at 10:50 AM, Resident #9 was in his room lying in bed. He had a blackish/ brownish substance underneath the middle and ring fingernails on his right hand. Resident #9's middle fingernail on his right hand was uneven around the edges. Resident #9 did not respond to questions or conversation about his nails. He was not interviewable. Record review of Resident #37's face sheet, dated 09/10/2025, reflected a [AGE] year-old male, admitted on [DATE]. Resident #37 had diagnoses which included unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (a condition where individuals experience cognitive decline consistent memory loss, impaired thinking, etc . without behaviors), legal blindness, as defined in USA (an eye which has limitation in the field of vision so that the widest diameter of the visual field was at an angle no greater than 20 degrees was considered to have a central visual acuity of 20/200 or less), age-related nuclear cataract, bilateral (clouding or hardening of the central part of the eye's lens of both eyes), and primary osteoarthritis in right and left shoulder (a degenerative condition where the protective cartilage in the shoulder joint wears away, leading to bones rubbing against each other, causing pain, stiffness, and loss of motion). Record review of Resident#37's Quarterly MDS Assessment, dated 08/29/2025, reflected Resident #37 had a BIMS score of 3, which indicated his cognition was severely impaired. Resident #37 required partial/moderate assistance (helper does less than half the effort) with the following: personal hygiene, lower and upper body dressing, showers, and oral hygiene. Record review of Resident #37's Comprehensive Care Plan, reflected Resident #37 (date initiated on 05/01/2024) had an ADL Self Care Performance Deficit. Interventions: he needed assistance with personal hygiene and bathing. During bathing check Resident #37's nail length, trim and clean on bath day and as needed. Report any changes to the nurse. Observation and interview on 9/09/2025 at 10:17 AM, revealed Resident #37 was in his room sitting in his wheelchair. He had a blackish/ brownish substance (continued on next page)		

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LVN C stated if a resident refused any type of care, the nurse would document the refusal in the nurse's notes. She stated Resident #9 and Resident #37 did not refuse care. She stated no one had reported to her Resident #9 or Resident #37 refused nail care. She stated she had been in-serviced on nail care, however, she did not recall the date. In an interview on 06/19/2025 at 9:20 AM, CNA D stated the CNAs were responsible for cleaning, trimming, and filing all residents' nails except for the residents with a diagnosis of diabetes. She stated the nurses were responsible for all the residents' nails with a diagnosis of diabetes. CNA D stated the residents' nails were usually cleaned on Sundays, their shower days and as needed. She stated if there was a blackish substance on the residents' fingertips or underneath their nails and the resident swallowed the blackish substance there was a possibility a resident may become ill such as vomiting and diarrhea. She stated a resident may cause a skin tear if their fingernails were not smooth. CNA D stated she was in-serviced on cleaning, filing, and trimming residents' nails but she did not recall the date. She stated she had given care to Resident # 9 and Resident #37, and they did not refuse nail care . She stated if any resident refused care it was reported to the nurse and the nurse would document the refusal in the nurses note. She stated he was in-serviced on nail care. CNA D stated she did not recall the date of the nail care in-service. In an interview on 06/19/25 at 10:30 AM, Treatment Nurse RN E stated the nurses, and the CNAs were responsible for nail care. She stated the nurses were responsible to trim and clean all resident's nails with a diagnosis of diabetes. She stated it was the CNAs' responsibility to clean and trim all other residents' nails during showers or as needed. She stated if there was a blackish substance underneath the resident's nails, there was a possibility the substance had bacteria. Treatment Nurse RN E stated if a resident swallowed the bacteria there was a possibility a resident may become ill with stomach problems such as vomiting. CNA C stated she was in-serviced on nail care; however, she did not recall the date. She stated she had given care to Resident #9 and Resident #37. She stated she was not aware of Resident #37 or Resident #9 refusing nail care. In an interview on 06/19/25 at 09:36 AM, the Assistant Director of Nurses stated if a resident ingested the blackish substance on their fingers or underneath their fingernails, there was a possibility the substance may be some type of bacteria, however it would be difficult to determine if the blackish/ brownish substance was bacteria. She stated it was a possibility a resident may become ill with stomach issues such as vomiting and diarrhea if they ingested the blackish/ brownish substance. She stated the CNAs were responsible for all residents' nails such as cleaning, trimming, and filing except for the residents with diabetes (a disease that occurs when your blood sugar, is too high). She stated for any resident with a diagnosis of diabetes the nurse was responsible for these residents' fingernails. The Assistant Director of Nurses stated the nurse supervisor was responsible for monitoring CNAs giving ADL care including nail care and she was responsible for monitoring the nurse supervisors. Record review of the facility policy on Nail Care, not dated, reflected Nail management is the regular care of the toenails and fingernails to promote cleanliness, and skin integrity of tissues, to prevent infection, and injury from scratching by fingernails or pressure of shoes on toenails. It includes cleansing, trimming, smoothing, and cuticle are and is usually done during the bath. Nails can become thinner and more brittle in the elderly and thicker if peripheral circulation is impaired. Nails are also important in assessment, as changes occur with certain medical conditions, such as clubbing with chronic obstructive pulmonary disease or cardiac disease. Color changes with circulatory or lymphatic impairment and certain drug therapy is common.		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility sponsored group and individual activities, and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community for two of eight residents (Resident # 9, and Resident #37) reviewed for activities. The facility failed to provide Resident #9, and Resident #37 in room activities on the dates of 8/11/2025 thru 8/31/2025. This failure could place residents at risk for boredom, depression, and a diminished quality of life. Findings included:Record review of Resident # 9's face sheet, dated 09/10/2025, reflected a [AGE] year-old male, admitted [DATE] and readmitted [DATE]. Resident #9 had diagnoses which included major depressive disorder, unspecified (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety disorder (a mental health disorder that produces fear, worry, and a constant feeling of being overwhelmed), other lack of coordination (the body's movements are not smooth, controlled, or precise resulting in unsteadiness, and difficulty with everyday tasks) and unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (a condition where individuals experience cognitive decline consistent memory loss, impaired thinking, etc. without behaviors). Record review of Resident #9's annual MDS Assessment, dated 06/16/2025, reflected Resident #9 had a BIMS score of 5, indicating severely impaired cognition. -Further review reflected Resident #9 indicated going outside to get fresh air was very important to him. The following activities was somewhat important such as reading books, being around pets, listening to music, keeping up with the news, and doing favorite activities. Record review of Resident #9's Comprehensive Care Plan, dated 07/20/2025, reflected Resident #9 had dementia. Interventions included: engage resident in simple, structured activities that avoid overly demanding tasks and provide a program of activities that accommodates the resident's abilities. Resident #3 had a communication problem related to cognitive communication deficit (caused by underlying problems with thinking processes, not a speech or language impairment) Interventions included be conscious of resident position when in groups, activities, dining room to promote proper communication with others. and provide a program of activities that accommodates the resident's communication abilities. Resident #9 needed out of room social, spiritual, and stimulus activities and mental stimulation. Intervention included the activity director will encourage and remind the resident of current activities. Resident is at risk for falls. Intervention: Encourage to participate in activities that promote exercise, physical activity for strengthening and improved mobility. Resident#9 needed activities that minimize the potential for falls while providing diversion and distraction. Record review of Resident #9's Participation Record, dated August 2025, reflected Resident # 3 did not receive in room activities from 08/11/2025 thru 08/25/2025. During an interview on 09/09/2025 at 11:45 AM, the Activity Director stated Resident # 9 did not want to attend very many group activities and changed his activity program the first week of August 2025 to receive in room activities 3 times per week. She stated her plan was to begin in room activities with Resident #9 on 08/11/2025. The Activity Director stated she was expected to ensure all residents received activities based on their preferences and their physical abilities. She stated if residents were not coming out of their room, the residents were to be provided in room activities. The Activity Director stated she provided in room activities at least twice a week. She stated there was not an excuse why Resident #9 did not receive in room visits. The Activity Director stated if a resident was not receiving activities on a consistent basis there was a potential a resident may become bored, depressed, or have a decline in their quality of lifeDuring an observation and interview on 09/09/2025 at 10:50 AM, Resident #9 was lying in bed staring at the wall in front of him. His television was not on in his room. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Franklin Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 700 Hearne St Franklin, TX 77856	
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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #9 was not interview able . Resident #9 did not respond to questions. Resident#9 cognition is severely impaired. Record review of Resident # 37's face sheet, dated 09/10/2025, reflected a [AGE] year-old male, admitted on [DATE]. Resident #37 had diagnoses which included unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (a condition where individuals experience cognitive decline consistent memory loss, impaired thinking, etc . without behaviors), legal blindness, as defined in USA (an eye which has limitation in the field of vision so that the widest diameter of the visual field was at an angle no greater than 20 degrees was considered to have a central visual acuity of 20/200 or less), age-related nuclear cataract, bilateral (clouding or hardening of the central part of the eye's lens of both eyes), and primary osteoarthritis in right and left shoulder (a degenerative condition where the protective cartilage in the shoulder joint wears away, leading to bones rubbing against each other, causing pain, stiffness, and loss of motion). Record review of Resident # 37's Annual MDS Assessment, dated 02/09/2025, reflected Resident #37 had a BIMS score of 5, which indicated his cognition was severely impaired. Further review reflected Resident #37 indicated listening to music was very important to him. with the following activities were somewhat important: being around pets, I keeping up with the news, and doing favorite activities. Record review of Resident#37's Quarterly MDS Assessment, dated 08/29/2025, reflected Resident #37 had a BIMS score of 3, which indicated his cognition was severely impaired. Record review of Resident #37's Comprehensive Care Plan, reflected Resident #37 (date initiated on 05/13/2024) had little or no activity involvement related to resident wishes not to participate. Resident #37 would participate in activities of choice 2 to 3 times per week. An intervention was to explain to the resident the importance of social interaction, leisure activity time, and encourage the resident's participation. Resident risk for weight loss. Intervention: Encourage food related activities. Record review of Resident #37's Participation Record, dated August 2025, reflected Resident #3 did not receive in room activities from 08/11/2025 thru 08/25/2025. During an observation on 09/09/2025 at 10:17 AM, Resident #37 was sitting in a wheelchair in his room. He was wearing sunglasses. Resident #37 was looking downward. He stated he did talk to his roommate, but he did not do any activities. Resident #37 stated he enjoyed music and would enjoy having music in his room. He stated he enjoyed all types of music except country. Resident #37 stated his roommate watched tv and he would try something go in his ears to listen to music. He stated he did not want to be in a group, and he rather do activities in his room. He did not respond if activity director visited him in his room or offered him music. Interview on 09/09/2025 at 11:45 AM, the Activity Director stated Resident # 37 did not want to attend group activities due to his impaired vision. She stated he preferred to receive activities in his room. The Activity Director stated she added Resident #37 to in room activities on 08/11/2025. She stated Resident #37's activity plan was adding him on the in-room activity program 2-3 times per week. The Activity Director stated she did not have an explanation of why Resident #37 did not receive in room activities during the time frame of 08/11/2025 thru 08/25/2025. Interview on 09/11/2025 at 9:40 AM, the Activity Director stated she was expected to ensure all residents received activities based on their preferences and their physical abilities. She stated if residents were not coming out of their room, had a decline of attending group activities, the residents were to be provided activities in their room. She stated if a resident was not receiving activities there was a possibility the resident may have become isolated, have a decline in their mental status, or become depressed. She stated it was her responsibility to provide in room activities. The Activity Director stated she forgot to visit Resident # 9 and Resident #37 during the month of August when she added both residents to the in-room activity program. Interview on 09/11/2025 at 11:00 AM, the Administrator stated he expected in room activities be provided to the residents needing these types of activities. He stated if a resident was not receiving in room activities there was a possibility a resident may become depressed, bored and isolated. He stated the Activity Director was responsible for all activities in the facility. He stated the Administrator would be responsible for monitoring the Activity Director. Record review of the Activity Director's personnel file (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed she was a certified Activity Profession through NCCAP (National Certification Council of Activity Professionals). Record review of The Facility's Activity Programming, dated 2019, revealed Activity programs are to be designed based on resident's leisure interest and implemented to meet the needs (physical, cognitive, social, spiritual, community, independent, and sensory) of the residents. Those who cannot participate in group settings are provided individual programming. Inability to participate could include those who refuse to participate in activities, those who are in isolation, or physician ordered bed rest. Record review of The Facility's Activity Documentation-General Guidelines, dated 2019, The following areas are considered documentation responsibilities of the Activity Director and staff and should be completed in a comprehensive and timely manner. Resident participation records.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences for 1 of 2 (Resident #1) reviewed for respiratory care. Findings included: Record review of Resident #1's undated Face Sheet printed on [DATE] revealed a [AGE] year old, male admitted to the facility on [DATE]. Diagnoses included Down Syndrome (genetic disorder), Seizures, and Cognitive Communication Deficit (problem with communication caused by cognition rather than a language or speech deficit). Record review of Resident #1's Annual MDS, dated [DATE], reflected Resident #1 was sometimes able to make himself understood and sometimes able to understand others. BIMS score for Resident #1 reflected 00 (severe cognitive impairment). Record review of Resident #1's Physician's orders printed on [DATE] at 1:09 PM reflected an order for Full Code dated [DATE], indicating a need for emergency care and resuscitation. There were no current orders for oxygen equipment or specialized respiratory care. Record review of Resident #1's Care Plan printed on [DATE] at 1:11PM reflected a Focus Area stating, Resident is Full Code. Date Initiated: [DATE]. Related Interventions/Tasks stated, Initiate BLS CPR if the resident is without a heartbeat or not breathing. Notify EMS (emergency medical services) Date Initiated: [DATE], and, Consult with nursing staff on changes in health. Date Initiated: [DATE]. Interventions for a Focus Area regarding Resident #1's seizure disorder reflected, SEIZURE PRECAUTIONS: Do not leave resident alone during a seizure, Protect from injury, If resident is out of bed, help to the floor to prevent injury, Remove or loosen tight clothing, Don't attempt to restrain resident during a seizure as this could make the convulsions more severe, Protect from onlookers, draw curtain etc. Date Initiated: [DATE]. Record review of Resident #1's Progress Notes [DATE] at 10:45AM reflected a note from LVN A stating, Res up in lobby initially noted having tremors. Res began vomiting then having seizure activity lasting 3-4 minutes. Lung sounds also significantly worsened, Spo2 dropped to 52 during seizure activity. Sent to [hospital] via RCEMS ([NAME] County Emergency Medical Services). At time of transfer res was continuing to have tremors, sats up to 72 on 5L O2(liters of oxygen). [Family member] called, informed of all, already at hospital for [Resident #1's other family member]. In an interview on [DATE] at 2:13PM, LVN A stated he was present on [DATE] when Resident #1 was sent out to the hospital. He stated Resident #1 was in the lobby when he started convulsing. He stated Resident #1 was breathing, but his oxygen levels were low, and he was sent out quickly. He stated prior to the incident the resident did not show any signs of respiratory changes or decline. He stated a crash cart was brought out during the episode. He stated emergency medical services were notified right away. He stated the ambulance was just down the road when they called and came very quickly. He stated the resident's oxygen improved some before the ambulance arrived. He stated he was not sure of the exact numbers for Resident #1's oxygen levels during the episode or prior to leaving the facility. He stated after the resident was sent out to the hospital, he notified the doctor, family, and the administration of the episode. He stated he thought he used a non-rebreather mask for the resident. He stated the proper oxygen flow for a non-rebreather was 8-10 LPM . He stated the bag attached to the oxygen mask does not need to fill. In an interview on [DATE] at 8:23'AM, the DON stated staff had monthly care related trainings and continuing education topics. She stated the nursing staff recently received a training regarding respiratory care. She stated that nurses in the facility are BLS Certified. She stated she expected the nurses to bring out the crash cart for a resident with a seizure or one showing signs of respiratory distress. She stated she expected one nurse to stay with the resident during an emergency, while the other calls for EMS (emergency medical services) and/or the physician. She stated a non-rebreather mask should be used during respiratory distress. She stated she did review the incident with Resident #1 on [DATE]. She stated (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that the proper oxygen flow level for a non-rebreather mask should be 5-10 LPM. She stated that she could not recall an interview with LVN A after the incident. She stated that she was not sure what type of oxygen supplies he used based on the note in the chart. She stated that she does look over the documentation and perform interviews, as needed, for discharges, but does not document those investigations unless there was a concern. She stated she had no additional investigation documentation for this event. She stated the EMS station was just around the corner and she knew that he was picked up very quickly. She stated that without effective oxygenation equipment and care a resident in respiratory distress would continue to decline. Observation on [DATE] at 09:02 AM of staff demonstration of the use of non-rebreather oxygen mask with LVN C and ADON revealed LVN C set the oxygen tank to 4 LPM with the non-rebreather mask and applied to ADON with the bag not inflated. She stated that she thought that residents with chronic lung conditions might be harmed by too high of a flow rate. She then stated that she may be wrong about the flow rate for chronic lung conditions and that during an emergency where a resident is in active respiratory distress, the oxygen flow rate should be turned up all the way. She stated that she had her BLS certification and had received respiratory skills training about a month prior. She stated that she does not use a non-rebreather mask often. ADON at that time stated she would use a non-rebreather with a starting flow rate of 10-15 LPM and make sure the bag was inflated prior to placing it on a resident. In an interview on [DATE] at 9:55AM, LVN A stated that he went back to look at the progress note he wrote about the incident. He stated that he must have used a nasal cannula rather than a non-rebreather mask for Resident #1 on [DATE]. He stated that a nasal cannula is not ideal for the situation, but that was what he grabbed first. He stated that he should have used a non-rebreather on high flow rate. He stated that the bag should inflate when the oxygen is turned on and prior to placing on the resident. He stated that the DON had in-serviced him on the use of a non-rebreather mask and emergency respiratory care that morning. He stated that he was BLS certified. He stated that he had attended a respiratory training about a month ago. He stated that there was a demonstration portion to the BLS course he attended. He stated that the potential impact to the resident of using the wrong oxygenation device or using the device improperly were that they could continue to decline. In an interview on [DATE] at 9:56AM, the ADON stated that she had BLS certification. She stated a NRB should be used with 10-15 LPM of oxygen and the bag on the mask should be filled when it is placed on the resident. In an interview on [DATE] at 09:58AM, the DON stated there was a skills demonstration component of the BLS class. She stated that the class is provided for nursing at the facility. She stated that given the status of Resident #1 at the time of the incident, from the documentation and interviews with staff, that a non-breather mask would have been the best choice, given his oxygen saturations were in the range of 50% when oxygen was started. In an interview on [DATE] at 10:04AM, the RNC stated during an emergency involving respiratory distress she expected the nurses to assess the residents and send them out. She stated that a non-rebreather mask would be the best choice for a resident in respiratory distress with low oxygen levels. She stated that you turn the oxygen flow rate to 10 or more liters and place the mask on the patient. She stated that the mask will fill on its own with the oxygen on and should be full during its use. She stated that the mask does not work if the bag is not full of oxygen to her knowledge. She stated that she would not use a nasal cannula for a resident in respiratory distress. She stated she was not aware of the incident on [DATE] when Resident #1 was sent out to the hospital. She stated it was the responsibility of the DON to review all discharges the next day. She stated that she should also have been notified if she was present in the building at the time of the incident. She stated that the last respiratory training for the nurses at the facility was about a month ago. She stated that she expected all nurses to know how to use a non-rebreather mask. She stated that if we do not provide effective oxygenation supplementation to residents in distress that the distress could continue. The facility's policy regarding seizure care or emergency care was requested. RNC stated that there was not a policy for seizure care or emergency care other than the facility policy for Notification of Physician for Change (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in Condition. In an interview on [DATE] at 11:05AM, the ADMIN stated his expectation regarding emergency care was that staff respond as quick as possible to get the resident the level of care needed. He stated that he expected nurses to follow the CPR training certification guidelines regarding care for respiratory distress. In a telephone interview on [DATE] at 11:40AM, the NP stated for the correct use of a non-rebreather mask the oxygen flow rate should be set to 10-15 LPM and the bag should be full. She stated that she would use a nasal cannula for a resident in respiratory distress if that was all she had, but standards of practice would indicate a non-rebreather mask should be used for respiratory distress. She stated that the resident could continue to decline if adequate oxygen was not provided during respiratory distress episodes. She stated she has confidence in the nurses at the facility and is informed well of care. She stated that the priority for Resident #1 in the situation on [DATE] was to be transferred to a higher level of care and that was done. She stated that the respiratory decline that occurred in hospital was unlikely to be related to the brief care the facility provided during the emergency. She stated that the resident was being treated for a respiratory infection at the time of the incident. She stated that it was normal to have a drop in oxygenation after a seizure. Record review of facility policy on [DATE] at 11:25AM for Notifying the Physician of Change in Status (no date) reflected that the policy does not give any indication of steps of care for a resident in an emergency situation or during respiratory distress.		