

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676457	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2025
NAME OF PROVIDER OR SUPPLIER The Bartlett Skilled Nursing and Assisted Living		STREET ADDRESS, CITY, STATE, ZIP CODE 221 Bartlett Drive 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)
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45217</p> <p>Based on interview and record review, the facility failed to ensure medical records were maintained on each resident that were complete and accurately documented for 1 (Resident #2) of 5 residents reviewed for resident records.</p> <p>-The facility failed to ensure the accuracy of Resident #2's medical records. The physician said to hold Resident #2's medication Donepezil due to an interaction and this was not in the medical records.</p> <p>This failure could put residents at risk of improper medication administration based on inaccurate documentation.</p> <p>Findings included:</p> <p>Record review of Resident #2's Admission Record dated 03/10/2025, revealed an [AGE] year-old male who was admitted to the facility on [DATE].</p> <p>Record review of Resident #2's History and Physical (H&P) dated 10/31/2024, revealed resident diagnoses to include Lewy body dementia (a decline in thinking ability, especially in areas of attention, visual perception, and planning and organization). Plan read in part: Continue donepezil and reorient patient frequently.</p> <p>Record review of Resident #2's MDS assessment dated [DATE], revealed a BIMS not conducted as the resident is rarely/never understood. Resident #2 with short-term memory problem and was severely impaired in daily decision making.</p> <p>Record review of Resident #2's hospital discharge summary dated 10/29/2024, reads in part under medication instructions the medication Donepezil daily, with no information regarding dosage, or any other instructions.</p> <p>Record review of Resident #2's Care Plan initiated 11/05/2024 revealed focus area which included: (Resident #2) had cognitive impairment AEB: memory problems: short/long term, and diagnosis of dementia. Part of the intervention plan includes administer medications as ordered.</p> <p>(continued on next page)</p>

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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #2's PCP Progress Notes for the dates of 11/05/24, 11/11/2024, 11/19/2024, 11/29/2024, 12/06/2024, and 12/12/2024 included the following information: Plan: Continue donepezil and reorient patient frequently.</p> <p>Record review of Resident #2's Order Summary from December 2024 did not reveal an order for Donepezil.</p> <p>Record review of Resident #2's October 2024, November 2024, and December 2024 Medication Administration Record (MAR) was reviewed. There was no information on any of the MARs for the medication Donepezil.</p> <p>Record review of Resident #2's Transfer/Discharge Report dated 03/10/2025, revealed Resident #2 was discharged from the facility on 12/17/2024 and transferred to board and care /assisted living/group home.</p> <p>During an interview on 03/12/2025 at 8:20 a.m., Resident #2's FM (Family Member) said Resident #2 was currently at home and stable and fully recovered from surgery he had back in October 2024 which led to Resident #2 being admitted to the facility. FM said Resident #2 was not given Donepezil that had been prescribed to him according to review of resident records discharge medication list. FM said she did not know why the medication was not given while Resident #2 was at the facility. FM said she spoke with someone at the facility and asked why he had not been given the medication and facility staff did not know that he was on that medication.</p> <p>During an interview on 03/12/2025 at 9:35 a.m., the PCP said Resident #2 was under his care while at the facility. The PCP said the Donepezil was used to prevent longer term memory loss. The PCP said Resident #2 was on two antibiotics that had a weird interaction with the medication Donepezil. The PCP said he gave the facility a verbal hold order on the medication since admission. The PCP said it was an error on his part to include the information to continue Donepezil on the progress notes. The PCP said the hold was to prevent side effects from the antibiotics that resident had been taking. The PCP said he visited the resident weekly and examined the resident and at no time did he find the resident in any acute distress. The PCP said the resident was alert and oriented times three (x3). The PCP said there was no negative outcome and there were no risks of any adverse effects from not taking the medication and keeping it on hold for over a month.</p> <p>During an interview on 03/13/2025 at 11:31 a.m., the DON said the facility follows hospital medication reconciliation when admitting a resident to the facility. The DON said for medication Donepezil, the hospital information did not list a dose for the medication. The DON said Resident #2's PCP verbalized there was a contraindication with the medication Donepezil and antibiotics that Resident #2 was supposed to follow-up with his primary physician when discharged from the facility . The DON said the verbalized information should have been documented by the nurse who received the information from the PCP on the progress notes. The DON said the information was not documented accordingly. The DON said she did not know why the physician notes continued to show Donepezil. The DON said there was no negative effects from Resident #2 not receiving the medication and he was discharged stable condition. The DON said Resident #2 was calm and alert during his stay and followed commands and was eating well. The DON said this was a documentation issue because she did not find any documented information about the verbalize instruction to hold the medication from the physician.</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 - Few</p>	<p>Review of facility provided Charting and Documentation policy dated July 2017, reads in part All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. Documentation in the medical record will be objective, complete, and accurate.</p>		