STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676457	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Bartlett Skilled Nursing and Assisted Living	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)
F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure residents were free from abuse, neglect, misappropriation of resident property, and exploitation for 2 of 5 residents reviewed for abuse. The facility failed to ensure Resident #1 was free from abuse when Resident #2 physically struck Resident #1 resulting in a bruise/hematoma to her forehead.This deficient practice placed residents at risk for further abuse. Findings include:1. Record review of Resident #1's face sheet, dated 8/6/25, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Record review of Resident #1's history and physical, dated 7/7/25, revealed diagnoses which included dementia (a group of symptoms associated with a decline in cognitive functioning, it can cause difficulty with simple tasks, confusion, memory loss and difficulty communicating), COPD (serious lung disease that over time makes it hard to breathe), chronic kidney disease stage 3 (type of long-term kidney disease, defined by the sustained presence of abnormal kidney function and/or abnormal kidney structure), and failure to thrive (state of decline that is multifactorial and may be caused by chronic concurrent diseases and functional impairments).Record review of Resident #1's quarterly MDS, dated [DATE], revealed a BIMS score of 03, which indicted her cognition was severely impaired.Record review of Resident #1's physician order, dated 6/19/25, revealed Eliquis oral Tablet 2.5mg by mouth two times a day to prevent DVT.Record review of Resident #1's incident report, dated 7/7/25 written by LVN A, revealed nurse description nurse went in during round to assess resident and noted discoloration to forehead; resident was unable to give description; bruise on top of scalp; was oriented to person; no predisposing factors noted; she was confused; and no predisposing situation factors identified. Record review of Resident #1's SBAR communication note, dated 7/7/25, revealed the change of condition was bruised forehead and left temple that started on 7/7/25 and was on anticoagulant, her vital signs were within normal range, no changes to mental and functional status.Record review of Resident #1's progress note, written by LVN A, dated 7/7/25 at 2:00 AM, revealed Upon rounding nurse observed discoloration to forehead of resident, nurse assessed site and noted no previous falls or incidents reported. Vital signs within normal limits, no open areas, no complaints of pain during shift, nurse reported to Dr. and RP. No new orders were given at this time.Record review of Resident #1's progress note, written by LVN B, dated 7/7/25 at 9:12 AM, revealed Resident send out per NP to local ER for evaluation and treatment of bruised forehead /temple. Report given to Dr. ResidentAOX1 pleasant response to question. Assisted total X1 person total with all ADLs transfers and mobility. Incontinent B/B wears briefs. Uses w/c for mobility. Denies pain, On O2 @2 LPM via NC at HS only. On room air in morning and evening but kept it on this morning. v/s 97.6 66 20 113/65 94% Ra.Record review of Resident #1's progress note, dated 7/7/25, at 5:45 PM, revealed Resident return from [local hospital] report given by [hospital nurse]. CT came back negative, urine negative, CT of spine negative. Returned at this time v/s 97 85 20164/90 93% O2 2 2 LPM via NC continuous. NP aware no new orders.Record review of Resident #1's Internal Medicine Progress Note, dated 7/7/25, revealed Patient was found to have new bruises on her forehead and face, to the left. She does not recall what happened. Denies falling. No other signs of trauma found on examination. Patient was sent to ER at [local hospital] and has returned in stable condition. No bleeding or fractures found.2. Record review of Resident #2's face sheet, dated 8/6/25, revealed a [AGE] year-old female who was admitted to the facility on [DATE].Record review of Resident #2's history and physical, dated 7/6/25, revealed a diagnosis which included mild intellectual disability.Record review of Resident #2's quarterly MDS, dated [DATE], revealed a BIMS score of 4, which indicated her cognition was severely impaired.Record review of Resident #2's care plan, dated 4/5/25, revealed focus area which documented she has a behavior problem, resident was observed hitting herself in the head, yelling and slamming the door with interventions Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Minimize potential for the resident's disruptive behaviors hitting self or others, by offering tasks which divert attention such as arts/crafts, manicure with nail polish. Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes. notify guardian when behaviors occur.Record review of Resident #2's progress notes from May 2025- August 2025 revealed no documented incidents prior to this event on 7/7/25, her history was limited to verbal behaviors towards others that warranted redirection and staff avoiding triggers, which included maintaining her preferred routine.Record review of HHSC witness

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Develop and implement policies and procedures to prevent abuse, neglect, and theft. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop and implement written policies and procedures that prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property for 2 of 4 residents (Resident#1 and Resident #2) reviewed for abuse. The facility failed to implement their abuse policy when they failed to report abuse when Resident #2 hit Resident #1. This failure could place residents at risk for abuse by not immediately following the facility policy and procedure manual of recognizing and reporting abuse. Findings include:1. Record review of Resident #1's face sheet, dated 8/6/25, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Record review of Resident #1's history and physical, dated 7/7/25, revealed diagnoses which included dementia (a group of symptoms associated with a decline in cognitive functioning, it can cause difficulty with simple tasks, confusion, memory loss and difficulty communicating), COPD (serious lung disease that over time makes it hard to breathe), chronic kidney disease stage 3 (type of long-term kidney disease, defined by the sustained presence of abnormal kidney function and/or abnormal kidney structure), and failure to thrive (state of decline that is multifactorial and may be caused by chronic concurrent diseases and functional impairments). Record review of Resident #1's quarterly MDS, dated [DATE], revealed a BIMS score of 03, which indicted her cognition was severely impaired. Record review of Resident #1's physician order, dated 6/19/25, revealed Eliquis oral Tablet 2.5mg by mouth two times a day to prevent DVT. Record review of Resident #1's incident report, dated 7/7/25 written by LVN A, revealed nurse description nurse went in during round to assess resident and noted discoloration to forehead; resident was unable to give description; bruise on top of scalp; was oriented to person; no predisposing factors noted; she was confused; and no predisposing situation factors identified.Record review of Resident #1's SBAR communication note, dated 7/7/25, revealed the change of condition was bruised forehead and left temple that started on 7/7/25 and was on anticoagulant, her vital signs were within normal range, no changes to mental and functional status.Record review of Resident #1's progress note, written by LVN A, dated 7/7/25 at 2:00 AM, revealed Upon rounding nurse observed discoloration to forehead of resident, nurse assessed site and noted no previous falls or incidents reported. Vital signs within normal limits, no open areas, no complaints of pain during shift, nurse reported to Dr. and RP. No new orders were given at this time.Record review of Resident #1's progress note, written by LVN B, dated 7/7/25 at 9:12 AM, revealed Resident send out per NP to local ER for evaluation and treatment of bruised forehead /temple. Report given to Dr. ResidentAOX1 pleasant response to question. Assisted total X1 person total with all ADLs transfers and mobility. Incontinent B/B wears briefs. Uses w/c for mobility. Denies pain, On O2 @2 LPM via NC at HS only. On room air in morning and evening but kept it on this morning. v/s 97.6 66 20 113/65 94% Ra. Record review of Resident #1's progress note, dated 7/7/25, at 5:45 PM, revealed Resident return from [local hospital] report given by [hospital nurse]. CT came back negative, urine negative, CT of spine negative. Returned at this time v/s 97 85 20164/90 93% O2 2 2 LPM via NC continuous. 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Record review of Resident #2's care plan, dated 4/5/25, revealed focus area which documented she has a behavior problem, resident was observed hitting herself in the head, yelling and slamming the door with interventions Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Minimize potential for the resident's disruptive behaviors hitting self or others, by offering tasks which divert attention such as arts/crafts, manicure with nail polish. Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes. notify guardian when behaviors occur. Record review of HHSC witness statement written by AIT, dated 7/7/25, revealed [Resident #1] was sent out to [local hospital] for evaluation, upon re-entering the facility

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed ensure alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 2 of 4 residents (Resident #1 and Resident#2) reviewed for reporting. The facility failed to report abuse when Resident #2 hit Resident #1 to State Office Agency, Law Enforcement, and Ombudsman.This failure could place residents at risk for abuse. Findings include:1. Record review of Resident #1's face sheet, dated 8/6/25, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Record review of Resident #1's history and physical, dated 7/7/25, revealed diagnoses which included dementia (a group of symptoms associated with a decline in cognitive functioning, it can cause difficulty with simple tasks, confusion, memory loss and difficulty communicating), COPD (serious lung disease that over time makes it hard to breathe), chronic kidney disease stage 3 (type of long-term kidney disease, defined by the sustained presence of abnormal kidney function and/or abnormal kidney structure), and failure to thrive (state of decline that is multifactorial and may be caused by chronic concurrent diseases and functional impairments). 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