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	04/11/2026

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to ensure efforts were made to resolve resident grievances, for 1 (Resident #2) of 6 residents reviewed for grievance resolution. The facility failed to follow their policy and procedure on Grievance/Complaints when Resident #2 lost his cell phone.This failure could place residents at risk of feeling that their voices were not being heard or taken seriously and could cause feelings of worthlessness. Findings included:Closed record review of the Face Sheet dated 04/10/26 for Resident #2 revealed an original admission date of 9/27/25. Resident discharged home on [DATE].Review of History & Physical dated 10/03/25 revealed Resident #2 was a [AGE] year-old-male with a past medical history of end stage renal disease on dialysis, diabetes Type 2, and Hypertension. Alert, oriented. admitted for rehabilitation and occupational therapy.Review of admission MDS dated [DATE] for Resident #2 revealed, Entry date 09/27/2025. BIMS Summary Score: 10 (moderately cognitive impaired).Review of Inventory dated 09/27/25 signed by Resident #2 documented Did not want inventory. Items not labeled.Review of IDT notes dated 09/06/25 through 10/07/25 did not document Resident #2 had lost his cell phone.During a telephone interview on 4/10/26 at 9:05 a.m., the Administrator said he was not aware of missing cell phones and could not remember if the Executive Director had reported this to him. He said when families or residents report missing personal items CNA Manager C immediately followed up on these concerns and usually most of the missing items were found.During an interview on 04/10/26 at 9:17 a.m., CNA Manager C revealed she assisted with trying to locate missing resident clothing and personal items and that 95% of the time the missing items were found. She said that usually reports of missing clothing and personal items such as phones are made to Executive Director by the families and/or staff, of missing items. She said she was not aware of the missing cell phone.During an interview on 04/10/26 at 9:45 a.m., the DON and LVN ADON D revealed that they did not remember anything about Resident #2 missing a cell phone. During an interview on 04/10/26 at 9:49 a.m., Receptionist B in the presence of the DON revealed that she had received a telephone call from someone at the dialysis center to report that Resident #3 had reported to them that he was missing his cell phone. She stated I wrote it down on a sticky note and gave it to the nurse and did not remember who the nurse was and asked the nurse to give the note to CNA Manager C. She said she was not aware of the facility's policy and procedure on Grievances and was not aware that she needed to fill out a concern form when she received complaints/concerns related to missing items. She said that she did not know if they had found the resident's cell phone. She said that the resident's family had come to pick up the resident's belongings.During an interview on 04/10/26 at 9:58 a.m., the DON revealed she remembered she had received a call from the dialysis center and did not remember who she had talked to about Resident #2's concern related to his missing cell phone. She said she had not written a Grievance/Concern form. She said they should have completed a Grievance/Concern according to the facility's Grievance policy and procedure to have documentation that grievances/concerns were addressed and resolved.During an interview on 04/10/26 at 10:01 a.m., CNA Manager C revealed Receptionist B had notified her of Resident #2's missing his cell phone. She (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

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 04/11/2026
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	

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	said she had alerted the laundry staff to see if it had been sent to the laundry with the linen. She said Receptionist C had not given her a Grievance/Concern form when she reported to her that the resident's cell phone was missing. She said that she did not know if the resident's cell phone was found. She said that she was not aware of the facility's Grievance policy.During an interview on 4/10/26 at 11:18 a.m., LVN H revealed he was assigned to Resident #2 on the day shift. He said Resident #2 was in the 200 Hall, was alert and oriented to person and place, required total assistance with ADLs and went to dialysis three times a week. He said that he remembered that the resident had a cell phone. He said that he could not remember if the resident had lost his cell phone. He said, I remember that Resident #2 called his daughter all of the time.During an interview on 4/10/26 at 11:50 a.m., LVN I revealed Resident #2 was confused, and had been discharged home with a family member. She said that she remembered that the resident had lost his old cell phone on the weekend and was never found. She said that the resident had poor vision and the staff would help him to dial the telephone numbers so he could call his daughter and wife. She said it was an old basic cell phone, and he was able to only use What's Up App to face time with his wife all the time. She said resident was sad that he had lost his cell phone because he could no longer communicate with his family.During an interview on 4/11/26 at 10:41 a.m., the Executive Director revealed the Social Worker was designated as the Grievance Officer and was responsible for following up on Grievances/Concerns. He said that he did not know that Resident #2 had lost his cell phone while he was at the facility.The state surveyor was unable to contact Resident #2 or his family during the investigation process due to family only having contact numbers in [another country].Review of facility's Grievances/Complaints, filing revised 2017 provided by Executive Director, revealed Policy Statement: Residents and their representatives have the right to file grievances, either orally or in writing, to the facility staff or the agency designated to hear grievances (e.g. the state Ombudsman). The administrator and staff will make prompt efforts to resolve grievances to the satisfaction of the residents and/or representatives. Policy Interpretation and Implementation: Any resident, family member or appointed resident representative may file a grievance or complaint concerning care, treatment, behavior of other residents, staff members, theft of property, or any other concerns regarding his or her stay at the facility. Grievances also may be voiced or filed regarding care that has not been furnished. Residents, families and resident representatives have the right to voice or file grievances without discrimination or reprisal in any form and without fear of discrimination or reprisal. Grievances and or complaints may be submitted orally or in writing and may be filed anonymously. The Administrator has delegated the responsibility of grievance and or complete investigations to the grievance officer who is. (was left blank) and can be contacted by (was left blank). Upon receipt of a grievance and/or complaint, the grievance officer will review and investigate the allegations and submit a written report of such findings to the administrator within 5 working days of receiving the grievance and/or complaint. The Grievance Officer will coordinate actions with the appropriate state and federal agencies, depending on the nature of the allegations. All alleged violations of neglect, abuse and/or misappropriation of property will be reported and investigated under guidelines for reporting abuse, neglect and misappropriation of property as per state law. The administrator will review the findings with grievance officer to determine what corrective actions if any need to be taken. The resident or person filing the grievance and or complaint on behalf of the resident will be informed verbally and in writing of the findings of the investigation and the actions that were taken to correct any identified problems. The administrator or his or her designee will make such reports orally within (was left blank) working days of the filing of the grievance or complaint with the facility. A written summary of the investigation will also be provided to the resident, and a copy will be filed in the business office. The results of all grievances files are investigated and reported will be maintained on file for a minimum of three years from the issuance of the grievance decision.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and record review, the facility failed to implement written policies and procedures to prohibit and prevent abuse, neglect, and exploitation the facility failed to complete Criminal History Check for 2 (LVN MDS Nurse O and Housekeeper P) of 10 employees reviewed for criminal checks. The facility failed to complete a Criminal History Check on Receptionist O and Housekeeper P upon hire.This failure could place residents at risk for abuse, neglect, exploitation, and misappropriation of property. Findings included:During an interview and record review on 4/11/26 at 2:29 p.m., Human Resource J revealed:- LVN MDS Nurse O Date of Hire was 10/06/21 and the Criminal Check was completed on 09/21/2021.-Housekeeper P Date of Hire was 03/09/26 and the Criminal Check was completed on 03/10/26.During an interview and record review on 4/11/26 at 3:30 p.m., Human Resource J revealed facility's policy revised 2019 provided by Human Resource J revealed, Policy Statement: Our facility conducts employment backgrounds, screening checks, reference checks and criminal conviction Investigation checks on all applicants for positions with direct access to the residents (direct access employees). Policy Interpretation and Implementation: The purpose of this policy direct access employees Means any individual who has access to a resident or patient of a long term care facility or provider through employment or through a contract and has duties that involved one to one contact with a resident of the facility or provide, as determined by the state for purposes of national background check program. The director of personnel or designee conducts background checks, reference checks, employee misconduct registry and criminal conviction checks on all potential direct access employees and contractors. Background employee misconduct, registry checks and criminal checks are initiated within two days of an offer of employment or contract agreement and completed prior to employment.Review of the facility's Abuse Prohibition Policy revised April 2021 revealed, Policy Statement: Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes, but is not limited to, freedom from corporal punishment and voluntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraints not required to treat the residents' symptoms. Policy Interpretation and Implementation: Conduct employee background checks and not knowingly employ or otherwise engage any individual who has: a. been found guilty of abuse, neglect, exploitation which appropriation of property, or mistreatment by a court of law. b. had a finding entered into the state Nurse Aid registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or c. a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents. The misappropriation of resident property.

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F 0627 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to follow written policy on permitting residents to return to the facility after they are hospitalized for one of (Resident #1) six residents reviewed for transfer and discharge.The facility failed to readmit Resident #1 to the facility after she was sent to the hospital on [DATE].This failure could place residents at risk of being discharged and not allowed to return to the facility causing a disruption in their care and services and potential for decline.Findings included:Closed record review of the Face Sheet dated 04/10/26 for Resident #1 revealed an original admission date of 5/20/19 and re-admission date 12/08/2023. Diagnoses: Unspecified Dementia (a general term for a group of brain disorders that cause a gradual decline in cognitive abilities such as memory, thinking, language, problem-solving, judgement, and orientation), Mild Intellectual Disabilities (a neurodevelopmental condition characterized by and IQ between 50-70 and limitations in adaptive functioning), Major Depression (is a serious mood disorder causing persistent sadness, hopelessness and loss of interest in activities, significantly affecting daily life, sleep, appetite and concentration), End Stage Renal Disease (permanent kidney failure where the kidneys function at less than 15% of normal capacity). Date of discharge: [DATE] at 8:45 p.m.Review of History & Physical dated 6/20/19 provided by the DON revealed Resident #1 had a Past Medical History: Chronic mental deficiencies, end stage renal disease on dialysis.Review of the Annual MDS for Resident #1 dated 12/07/25 revealed: Level; II PASRR Conditions: Intellectual Disability. Reentry Date: 12/08/2023. admission Date: 05/20/19. Makes self usually understood. Usually understand others. Impaired vision. BIMS Summary Score: 4 (cognition severely impaired). Interview for Daily Preferences: Very Important to choose clothes to wear, bedtime, shower and have family or close friends involved in discussions about her care. Moderate assistance with toileting, oral hygiene, dressing, personal hygiene; substantial/maximum assistance with shower. Partial/moderate assistance sit to stand and chair/bed transfer. Mobility Device: Wheelchair. Active Diagnoses: ESRD, Non-Alzheimer's Dementia, Anxiety, Depression, Mild intellectual disabilities. High-Risk Drug Classes: Antipsychotic; dialysis. Discharge Plan: No. Return to Community: NoReview of the Care Plan for Resident #1 dated 12/30/25 revealed:-Resident uses psychotropic medication: Risperdal as ordered-Communication problem r/t cognitive deficits and intellectual disabilities-Behavior problem hitting herself on the head, yelling, slamming doors, hitting/slapping another patient, if someone is sitting where she likes to sit. Middle finger to staff, residents and visitors as she is wheeled down the hall.-Uses anti-anxiety mediation r/t anxiety disorder.-Major depressive disorder at risk of fluctuations in moods and decreased socialization. On antidepressant medication.-Resident has intellectual disabilities.Review of Psychiatric Follow-Up Evaluation dated 12/07/25 for Resident #1 revealed, Alert and oriented to person, cooperative, slow speech. Mood: Euthymic (tranquil, and normal mood), poor insight. Psychiatric Diagnosis: Unspecified Dementia without behavioral disturbances, Major depressive disorder, recurrent, moderate. Anxiety unspecified. Continue Risperidone 0.5 mg BID for dementia and aggressive behavior.Review of an Initial Psychiatry Note dated 1/08/26 written by the DNP for Resident #1 revealed a [AGE] year-old female and a long-term resident at this facility. She was seen per family's request. She was calm and cooperative. She smiles and answers yes and no to questions. She responded no to sadness and society and anger. Collateral information received from the nursing staff. The patient has a history of harming others, Combativeness and gets angry if she doesn't get what she wants immediately. She becomes combative, threatens staff, becomes verbally aggressive, and curses him. The patient tends to be possessive and wants the same staff to provide care. She has refused to go to dialysis and the driver she prefers is not available to take her. Assessment data: Mild recurrent. Major depressive disorder, Unspecified incident disorder. Unspecified dementia. With other behavioral disturbances. Plan: The (continued on next page)

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F 0627 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	back to the facility at the time that she was discharged from the hospital on 2/14/26. The executive Director stated she could not have a roommate to prevent recurrence of her hitting other residents, which was why the facility had been cited by another surveyor. He said that he had not offered a bed hold to the resident's guardian when the resident was admitted to the hospital on [DATE]. He said he believed the facility's policy was to offer a bed hold at time of transfer. He said, I did not offer a bed hold for the last hospitalization because we did not have any beds available to bring her back. I called the Resident #1's ardian to inform her that Resident #1 could not be re-admitted because they did not have any beds available at the facility at the time of discharge from the hospital on 2/14/26. He denied receiving any call from the resident's guardian to report that Resident #1 had pneumonia on the last hospital admission. He said he had not offered a 30-day notice. He said the case manager called regarding Resident #1's pending discharge, could not remember the date and he had informed them that he had no beds available. He said, I had a full house on February 14, 2026. The state surveyor requested copies of the census reports for February 2026 when the case worker called him, and he had informed them that he did not have any beds available at the time that Resident #1 was ready to be discharged from the hospital on 2/14/26.During an interview on 04/10/26 at 10:46 a.m., LVN E on the 6-2 shift revealed Resident #1 had unclear speech, could make needs known, required total assistance with showers, toileting, dressing, and was able to ambulate, but preferred to use a wheelchair. She went to dialysis on Monday-Wednesday-Fridays. She had some behaviors such as cussing at staff if they did not give her immediate assistance or attention, would throw things on the floor, had temper tantrums, and would hit herself on her legs. She said there was one incident where Resident #1 hit another resident and could not remember if the other resident was injured. She said Resident #1 had been sent to the hospital due to an upper respiratory infection and shortness of breath.During an interview on 4/10/26 at 11:08 a.m., LVN G on the day shift revealed Resident #1 had intellectual disabilities, was oriented to person and place, required minimum to moderate assistance with ADLS. She said the resident went to dialysis 3 x a week on Monday-Wednesday-Fridays. She said the resident had behaviors and would yell and scream at staff when she was having a temper tantrum. She said Resident #1 became very upset if the staff did not follow her daily routine and would resist care until she calmed down. She said that they had been informed that Resident #1 had an altercation with another resident and did not know if the other resident was injured. She said that she could not remember who had told her that the resident was not allowed to have a roommate and was not told why. She said the resident was sent to the hospital after she had returned from dialysis on a Friday 02/02/26. She said the resident was in respiratory distress and was transported to the hospital by EMS. She said the resident had been admitted to the hospital and did not know why she had not returned to the facility.During a telephone interview on 4/10/26 at 3:39 p.m., the PASRR Unit Supervisor said the facility did not want Resident #1 to return to the facility after she had been sent to the hospital on 2/02/26 and had been there for several days. She said the Executive Director said he did not want Resident #1 to return to the nursing facility because he got a citation because Resident #1 had hit another resident in July 2025 and was still at the facility. She said Resident #1 was sent to the hospital on 2/02/26 and was admitted for pneumonia. She said she and the resident's Guardian had placed multiple telephone calls to the facility's Executive Director and had also sent him an email and he did not answer any of the calls or respond to her email regarding Resident #1's discharge from the hospital and had been discharged from the hospital on 2/14/26 and needed to return to the nursing facility. She said that the Executive Director made it very clear that he did not want Resident #1 back at the facility. She said they had a Family Conference on 10/09/25 with the Executive Director, MDS Nurse, Care Coordinator, DON, Local Ombudsman, Resident's Guardian and a Nurse Practitioner. The Executive Director said that the facility had been converted to short-term stay facility and residents did not stay at the facility for more than 30 days. He said that Resident #1 needed to be placed in a stable LTC placement and not be at a facility that had a high turnover of short-term residents. She said the Ombudsman had asked the Executive Director if he was going to (continued on next page)

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She said some of the nurses, therapy staff, and office staff were in a hurry to give her the boxes that contained Resident #1's belongings on that day, to get her out of the facility as soon as possible and no one assisted her in putting the boxes in her car. She said she noted a few missing items, and they told me that they did not know what happened to them. She said the Executive Director had been trying to discharge Resident #1 from the facility for a long time and that was why he had not allowed Resident #1 to return to the facility when the hospital called the facility on 2/14/26 to let them know that Resident #1 was ready to be discharged from the hospital. She said that the Executive Director called her to let her know that they did not have rooms available for Resident #1 to return to facility. She said the Executive Director had never offered a bed hold when Resident #1 was admitted to the hospital on [DATE]. She said Resident #1 had been at the facility for seven years and it was like her home. She said the Executive Director had arranged for a family meeting to meet with her, the Executive Director, ombudsman, the supervisor from the PASRR unit, and a Nurse Practitioner. She said the meeting was about discharging Resident #1 from the facility because they could not meet her needs and needed 1:1 supervision. She said, All they kept saying was that Resident #1 was very demanding. No one at the facility could give me a reason why Resident #1 could not return to the facility and they had never given Resident #1 a 30-day notice. She said Resident #1 had been admitted to the hospital with pneumonia on 2/02/26. She said resident's primary physician had called her on Sunday 2/15/26 to ask her why Resident #1 as still at the hospital because he had given a discharge order last night on Saturday 2/14/26. She said, I started looking for another facility on that day right after the physician had called me to let me know that he had given a discharge order on Saturday 2/14/26. She said she had informed the physician that the Social Worker at the hospital had informed her on 2/14/26 that the nursing facility did not have any beds available and needed to go to another facility. She said the physician said that he was going to call the Executive Directo to ask him why the facility had refused to allow Resident #1 to return to nursing facility. She said she started looking for another facility on Sunday 2/14/26 and Resident #1 had to stay in the hospital until she found a facility that was willing to take her on 2/17/26. She said Resident #1 was very depressed for a month, was not eating and did not want to go to dialysis because she wanted to go back to facility that had been her home for seven years and kept saying she wanted to go back home. She said that Resident #1 was slowly adjusting to being at the new facility. She said that after an incident when Resident #1 had hit an old lady at the facility, the Executive Director had started to tell her that Resident #1 could no longer be at the facility.During an interview on 4/10/26 at 4:31 p.m., the Executive Director in the presence of the DON and the Care Coordinator who is now HR Manager, revealed that the Executive Director had scheduled a Family Meeting with the Local Ombudsman, NP, MDS Nurse, PASRR Supervisor and resident's Guardian. The Executive Director said that he had made the decision to schedule this meeting to discuss and get everyone on the same page about why Resident #1 needed to be discharged from another facility. The Executive Director said Resident #1 had erratic behaviors such as throwing the middle finger at the staff when she became upset when she did not get her way, cursing and hitting the staff when care was provided, hitting herself on the legs when she became upset. He said that the facility had also been cited because Resident #1 had hit her roommate and he had made the decision that Resident #1 could not be in a room with a roommate to prevent her from hitting other residents. He said, We wanted to explain to the resident's Guardian, the Ombudsman and (continued on next page)

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 04/11/2026

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 0627 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	the PASRR Supervisor why Resident #1 was not appropriate to be at nursing facility because of the constant flow of residents that were admitted for short term rehab was not appropriate for Resident #1 and would do better in a LTC facility. He said that he had not offered a 30-day notice to the resident during the Family Meeting and the facility did not have any documentation in the resident's clinical record about what had been discussed during the Family Meeting on 10/09/25. He said they had packed the resident's belongings in cardboard boxes for the Guardian to come and pick them up since they did not have any beds available on 2/14/26 and 2/15/26 to readmit Resident #1 when she was ready to be discharged from the hospital. He said that the Guardian had voice that several personal items such as clothing and tennis shoes were missing at the time the personal belongings had been picked up by the Guardian and could not remember the date. He said We did not issue a 30-day discharge notice. He said that the facility had the right to discharge a resident if they thought the resident was a threat to themselves or others. He said, we did not give her a 30-day notice or offered a bed-hold when she was admitted to the hospital. During an interview and record review on 4/10/26 at 4:41 p.m., the Executive Director in the presence of the DON revealed they did not have any written documentation in Resident #1's electronic record regarding the room change from a private room to a semi-private room that was done in July 2025. They said that the facility did not have any documentation in the resident's clinical record that they had offered a bed-hold when Resident #1 was admitted to the hospital on [DATE]. He said the facility did not have any documentation when the resident's Guardian had come to pick up her personal belongings and/or signed the personal inventory form when the resident was discharged from the hospital and could not be re-admitted because the facility did not have any beds available. He said they had not completed a Grievance/Concern form when the resident's Guardian reported the resident was missing tennis shoes and clothing. He said he could not remember when this had been reported and to whom it was reported.During an interview on 4/10/26 at 4:53 p.m., former Care Coordinator J revealed that now he was Human Resources. He said that he assisted with admissions and discharges and would make referrals to the Social Worker. He said, I remember that we had a family meeting on 10/9/25 with Executive Director, DON, MDS Nurse, Ombudsman, PASRR Unit supervisor and the resident's Guardian. I do not remember what was discussed at the meeting. All we wanted was a good place for Resident #1 because the level of care provided at this facility was not appropriate for Resident #1 and would do better in a facility that did not have a high number of discharges and could become familiar of other residents in a LTC facility. She said Resident #1 would become easily frustrated if she did not get her way or if other residents were assisted before her, then she would start cussing, and calling the staff whores and would start throwing things on the floor. He said that he never saw Resident #1 verbally or physically abuse any of the residents. He said, I only witnessed when she mistreated the staff, by cussing, swearing, and calling them whores when she was having a temper tantrum.During an interview and record review on 4/10/26 at 5:00 p.m., LVN MDS Nurse O revealed she had attended the family meeting on 10/09/26 to inform Resident #1's guardian why Resident #1 needed to be discharged to another facility that provided LTC services. She said, That is all that I can remember. We did not document in the resident's electronic record any notes about the meeting that was held on 10/09/25.During an interview on 4/11/26 at 9:42 a.m., LVN L revealed he was assigned to Resident #1. He said Resident #1 had intellectual disabilities, had temper tantrums, would herself on her legs when she became upset, was able to ambulate, but preferred to use a wheelchair, throw things on the floor when she became upset, and yelled at the staff at times when care was provided. He said he never saw Resident #1 hit other residents or the staff. He said he had heard about an incident where she had hit one of the residents. He said Resident #1 had been sent to the hospital on 2/02/26 for shortness of breath, low oxygen saturation and labored breathing. He said that Resident #1 did not like to go to the hospital. He said Resident #1 had not returned after she was sent to the hospital and her belongings had been picked up by her Guardian during the weekend. He said that the resident's Guardian always complained that Resident #1 was missing clothes and shoes.During an (continued on next page)

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F 0627 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	interview on 4/11/26 at 10:17 a.m., CNA M revealed Resident #1 had been at the facility since 2020, was stubborn and only wanted things done her way. She said, She always wanted to be first, and if not, she would have a temper tantrum. She said that when she had a tantrum, she would cuss at the staff and hit herself on the legs, pulled her hair, and yelled. She said the resident was always in a private room, was moved to a semi-private room and had gotten a roommate prior to discharge. She said the roommate was a very quiet lady, and calm. She said that the DON had interviewed her regarding an injury that the roommate had on her face. The incident happened on a Sunday, and the resident did not have any apparent injuries. She said Resident #1 would walk but preferred to use a wheelchair. She said the resident waited for the morning staff by the door so they could give her a shower as soon they reported to work, and if not, she would get mad and would not shower.Review of the facility's Bed-Holds and Returns policy revised on October 2022 provided by the Executive Director revealed: Policy Statement: Residents and/or representatives are informed in writing of the facility and state bed-hold policies. Policy Interpretation and Implementation: All residents/Representatives are provided with written information regarding the facility and state bed-hold policies, which address holding or reserving a residence bed during periods of absence (hospitalization or therapeutic leave). Residents, regardless of payment source, are provided with written notice about these policies at least twice: Notice 1: well in advance of any transfer; and notice 2: at the time of transfer (or if the transfer was an emergency, within 24 hours). Reissuance of notice 1: must occur if either the bed hold policy under the state plan or facility policy changes after the notice is issued. Multiple attempts to provide the resident representative with notice 2: should be documented in cases where staff were unable to reach and notify the representative timely. The written bed-hold, notices provided to the resident/representative explain in detail: The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the facility; the reserve bed payment policy is indicated by the state plan (for Medicaid residents); the policy regarding bed hold periods; the facility per diem required to hold the bed (for non-Medicaid residents), or to hold a bed beyond the state bed-hold policy (for Medicaid residents), or to hold a bed beyond the state bed-hold period (for Medicaid resident); and the facility return policy. The requirement that residents be permitted to return to the facility following hospitalization or therapeutic leave applies to all residents regardless of Payer source. Residents who seek to return to the facility within the bed-hold period defined in the state plan or allowed to return to their previous room, if available. If the facility determines that a resident cannot return, the facility must comply with the requirements for facility-initiated discharges. Residents are not discharged unless: The discharge or transfer is necessary for the resident's welfare and the facility cannot meet the resident's needs.; The residents have has improved sufficiently, so that the resident no longer needs the services of the facility; The resident's clinical or behavioral status endangers the safety of individuals in the facility; The resident's clinical or behavioral status endangers the health of individuals in the facility; and/or; the resident has failed, after reasonable and appropriate notice, to pay for his or her stay at the facility. Following a hospitalization, residents whom staff are concerned about permitting to return due to their clinical/behavioral condition at the time of transfer are evaluated based on their current condition, not their condition when originally transferred. Medicaid residents who have outstanding Medicaid balances are still permitted to return to the first available Bed.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure, in accordance with accepted professional standards and practices, medical records were maintained on each resident that were accurately documented for 2 (Resident #1 and Resident #2) of 6 residents reviewed for medical records. -The facility failed to document in Resident #1's electronic clinical record when the Executive Director had the staff moved to another room.-The facility failed to document in Resident #1's electronic clinical record when the Executive Director held a family meeting on 10/09/25 to discuss the need to transfer resident to another facility.-The facility failed to document in Resident #1's electronic clinical record when the hospital staff was informed by the Executive Director on 2/14/26 that Resident #1 would not be re-admitted to the facility, when she was ready to be discharged from the hospital.The facility failed to document in Resident#1's electronic clinical record when the Guardian for Resident #1 went to the facility on 2/17/26 to pick up the resident's belongings.-The facility failed to document in Resident #2's electronic clinical record when they received a telephone from the dialysis center to report that the resident had reported that his cell phone was lost at the nursing facility.This failure could place residents at risk of resident's records not reflecting accurate and complete information. Findings include:Closed record review of the Face Sheet dated 04/10/26 for Resident #1 revealed an original admission date of 5/20/19 and re-admission date 12/08/2023. Diagnoses: Unspecified Dementia, Mild Intellectual Disabilities, Major Depression, End Stage Renal Disease. Resident #1 had a change in condition and was discharged to the hospital on 2/02/26.Review of History & Physical dated 6/20/19 provided by DON revealed Resident #1 had a Past Medical History: Chronic mental deficiencies, end stage renal disease on dialysis.Review of the Annual MDS for Resident #1 dated 12/07/25 revealed: Level; II PASRR Conditions: Intellectual Disability. Reentry Date: 12/08/2023. admission Date: 05/20/19. Makes self usually understood. Usually understand others. Impaired vision. BIMS Summary Score: 4 (cognition severely impaired). Interview for Daily Preferences: Very Important to choose clothes to wear, bedtime, shower and have family or close friends involved in discussions about her care. Moderate assistance with toileting, oral hygiene, dressing, personal hygiene; substantial/maximum assistance with shower. Partial/moderate assistance sit to stand and chair/bed transfer. Mobility Device: Wheelchair. Active Diagnoses: ESRD, Non-Alzheimer's Dementia, Anxiety, Depression, Mild intellectual disabilities. High-Risk Drug Classes: Antipsychotic; dialysis. Discharge Plan: No. Return to Community: No.Review of Psychiatric Follow-Up Evaluation dated 12/07/25 for Resident #1 revealed, Alert and oriented to person, cooperative, slow speech. Mood: Euthymic (tranquil, and normal mood), poor insight. Psychiatric Diagnosis: Unspecified Dementia without behavioral disturbances, Major depressive disorder, recurrent, moderate. Anxiety unspecified. Continue Risperidone 0.5 mg BID for dementia and aggressive behavior.Review of Nursing Note dated 2/02/26 at 8:00 p.m., for Resident #1 written by LVN L revealed, Patient sent to hospital for SOB and decreased oxygen level.Record review of Resident #1's electronic record revealed there was no documentation of written notification to the resident's RP or the LTC Ombudsman of the resident's discharge from the facility. The facility did not have any documentation in the resident's clinical record when resident was moved from the private room to a semi-private room.During an interview on 4/10/26 at 9:20 a.m., the Executive Director revealed, Resident #1 had been long term placement at facility for many years. He said the resident had been discharged to the hospital, could not remember the dates and the resident had been in ICU for 10-16 days and was not re-admitted on [DATE] because the facility was full and there were no beds available when she was ready to be discharged from the hospital. He said that he had made the decision that Resident #1 could not be placed in a semi-private room with another resident, after an incident in July 2025 when Resident #1 had hit her roommate. He said that there was only one bed available in a semi-private room and there was a (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident in one of the beds, so that was why Resident #1 could not be re-admitted back to the facility at the time that she was discharged from the hospital on 2/14/26 because she could not have a roommate to prevent recurrence of her hitting other residents and that was why the facility had been cited by another surveyor. He said that he had not documented in the resident's electronic record when he had informed the hospital that Resident #1 could not return to the facility due to not having a bed available at the time of the discharge from the hospital.During an interview on 4/10/26 at 11:08 a.m., LVN G on the day shift revealed Resident #1 had intellectual disabilities, was oriented to person and place, required minimum to moderate assistance with ADLS. She said the resident went to dialysis 3 x a week on Monday-Wednesday-Fridays. She said the resident had behaviors and would yell and scream at staff when she was having a temper tantrum. She said Resident #1 became very upset if the staff did not follow her daily routine and would resist care until she calmed down. She said that they had been informed that Resident #1 had an altercation with another resident and did not know if the other resident was injured. She said that she could not remember who had told her that the resident was not allowed to have a roommate and was not told why. She said the resident was sent to the hospital after she had returned from dialysis on a Friday 02/02/26. She said the resident was in respiratory distress and was transported to the hospital by EMS. She said the resident had been admitted to the hospital and did not know why she had not returned to the facility.During a telephone interview on 4/10/26 at 3:39 p.m., the PASRR Unit Supervisor said the facility did not want Resident #1 to return to the facility after she had been sent to the hospital on 2/02/26 and had been there for several days. She said the Executive Director had said that he did not want Resident #1 to return to the nursing facility because he got a citation because Resident #1 had hit another resident in July 2025 and was still at the facility. She said Resident #1 was sent to the hospital on 2/02/26 and was admitted for pneumonia. She said she and the resident's Guardian had placed multiple telephone calls to facility's Executive Director and had also sent him an email and he did not answer any of the calls or respond to her email regarding Resident #1's discharge from the hospital and had been discharged from the hospital on 2/14/26 and needed to return to the nursing facility. She said that the Executive Director had made it very clear that he did not want Resident #1 back at the facility. She said they had a Family Conference on 10/09/25 with the Executive Director, MDS Nurse, Care Coordinator, DON, Local Ombudsman, Resident's Guardian and a Nurse Practitioner. The Executive Director said that the facility had been converted to short-term stay facility and residents did not stay at the facility for more than 30 days. He said that Resident #1 needed to be placed in a stable LTC placement and not be at a facility that had a high turnover of short-term residents. She said the Ombudsman had asked the Executive Director if he was going to issue a 30-day notice that documented why they could not meet Resident #1's needs. She said the facility had not given the resident a 30-day discharge notice when the resident was transferred to the hospital with a diagnosis of pneumonia.During a telephone interview on 4/10/26 at 4:17 p.m., Resident #1's Guardian revealed the Executive Director at the facility had not allowed her to enter the facility on Tuesday 2/17/26 when she went to the facility to pack Resident #1's belongings. She said, I was asked to stay at the front entrance of the facility, and they would bring me Resident #1's belonging. She said the facility had already packed Resident #1's belongings in cardboard boxes and they just handed her the cardboard boxes, and no one talked to her on that day. She said some of the nurses, therapy staff, and office staff were in a hurry to give her the boxes that contained Resident #1's belongings on that day, to get her out of the facility as soon as possible and no one had assisted her in putting the boxes in her car. She said she had noted a few missing items, and they told me that they did not know what had happened to them. She said the Executive Director had been trying to discharge Resident #1 from the facility for a long time and that was why he had not allowed Resident #1 to return to the facility when the hospital called the facility on 2/14/26 to let them know that Resident #1 was ready to be discharged from the hospital. She said that the Executive Director had called her to let me know that they did not have rooms available for Resident #1 to return to facility. She said the Executive Director (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	had never offered a bed hold when Resident #1 was admitted to the hospital on [DATE]. She said Resident #1 had been at the facility for seven years and it was like her home. She said the Executive Director had arranged for a family meeting to meet with her, the Executive Director, ombudsman, the supervisor from the PASRR, and a Nurse Practitioner. She said the meeting was about discharging Resident #1 from the facility because they could not meet her needs and needed 1:1 supervision. She said, All they kept saying was that Resident #1 was very demanding. No one at the facility could give me a reason why Resident #1 could not return to the facility and they had never given Resident #1 a 30-day notice. She said Resident #1 had been admitted to the hospital with pneumonia on 2/02/26. She said resident's primary physician had called her on Sunday 2/15/26 to ask her why Resident #1 was still at the hospital because he had given a discharge order last night on Saturday 2/14/26. She said, I started looking for another facility on that day right after the physician had called me to let me know that he had given a discharge order on Saturday 2/14/26. She said she had informed the physician that the Social Worker at the hospital had informed her on 2/14/26 that the nursing facility did not have any beds available and needed to go to another facility. She said the physician said that he was going to call the Executive Director to ask him why the facility had refused to allow Resident #1 to return to nursing facility. She said she started looking for another facility on Sunday 2/14/26 and Resident #1 had to stay in the hospital until she found a facility that was willing to take her on 2/17/26. She said Resident #1 was very depressed for a month, was not eating and did not want to go to dialysis because she wanted to go back to facility that had been her home for seven years and kept saying she wanted to go back home. She said that Resident #1 was slowly adjusting to being at the new facility. She said that after an incident when Resident #1 had hit an old lady at the facility, the Executive Director had started to tell her that Resident #1 could no longer be at the facility.During an interview on 4/10/26 at 4:31 p.m., the Executive Director in the presence of the DON and the Care Coordinator who is now HR Manager, revealed that the Executive Director had scheduled a Family Meeting with the Local Ombudsman, NP, MDS Nurse, PASRR Supervisor and resident's Guardian. The Executive Director said that he had made the decision to schedule this meeting to discuss and get everyone on the same page about why Resident #1 needed to be discharged to another facility. The Executive Director said Resident #1 had erratic behaviors such as throwing the middle finger at the staff when she became upset when she did not get her way, cursing and hitting the staff when care was provided, hitting herself on the legs when she became upset. He said that the facility had also been cited because Resident #1 had hit her roommate and he had made the decision that Resident #1 could not be in a room with a roommate to prevent her from hitting other residents. He said, We wanted to explain the resident's Guardian who was the resident's sister, the Ombudsman and the PASRR Supervisor and the [NAME] why nurse was not appropriate to be at nursing facility because of the constant flow of residents that were admitted for short term rehab was not appropriate for Resident #1 and would do better in a LTC facility. He said that he had not offered a 30-day notice to the resident during the Family Meeting and the facility did not have any documentation in the resident's clinical record about what had been discussed during the Family Meeting on 10/09/25. He said they had packed the resident's belongings in cardboard boxes for the Guardian to come and pick them up since they did not have any beds available on 2/14/26 and 2/15/26 to readmit Resident #1 when she was ready to be discharged from the hospital. He said that the Guardian had voice that several personal items such as clothing and tennis shoes were missing at the time the personal belongings had been picked up by the Guardian and could not remember the date. He said We did not issue a 30-day discharge notice. He said that the facility had the right to discharge a resident if they thought the resident was a threat to themselves or others. He said, we did not give her a 30-day notice or offered a bed-hold when she was admitted to the hospital. During an interview and record review on 4/10/26 at 4:41 p.m. with Executive Director in the presence of the DON, revealed they did not have any written documentation in Resident #1's electronic regarding the room change from a private room to a semi-private room that was done in July 2025. They said that the facility did not (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	have any documentation in the resident's clinical record that they had offered a bed-hold when Resident #1 was admitted to the hospital on [DATE]. He said the facility did not have any documentation when the resident's Guardian had come to pick up her personal belongings and/or signed the personal inventory form when the resident was discharged from the hospital and could not be re-admitted because the facility did not have any beds available. He said they had not completed a Grievance/Concern form when the resident's Guardian had reported the resident was missing tennis shoes and clothing. He said he could not remember when this had been reported and to whom it was reported.During an interview and record review on 4/10/26 at 5:00 p.m., LVN MDS Nurse O revealed she had attended the family meeting on 10/09/26 to inform the Resident #1s' guardian why Resident #1 needed to be discharged to another facility that provided LTC services. She said, That is all that I can remember. We did not document in the resident's electronic record any notes about the meeting that was held on 10/09/25.During an interview on 4/11/26 at 9:42 a.m. with LVN L revealed, he was assigned to Resident #1. He said Resident #1 had been sent to the hospital on 2/02/26 for shortness of breath, low oxygen saturation and labored breathing. He said Resident #1 had not returned after she was sent to the hospital and her belongings had been picked up by her sister who was her Guardian during the weekend.Resident #2Closed record review of the Face Sheet dated 04/10/26 for Resident #2 revealed an original admission date of 9/27/25. Resident discharged home on [DATE].Review of History & Physical dated 10/03/25 revealed Resident #2 was a [AGE] year-old-male with a past medical history of end stage renal disease on dialysis, diabetes Type 2, and Hypertension. Alert, oriented. admitted for rehabilitation and occupational therapy.Review of admission MDS dated [DATE] for Resident #2 revealed, Entry date 09/27/2025. BIMS Summary Score: 10 (moderately cognitive impaired).Review of Inventory dated 09/27/25 signed by Resident #2 documented Did not want inventory. Items not labeled.Review of IDT notes dated 09/06/25 through 10/07/25 did not document Resident #2 had lost his cell phone.During a telephone interview 4/10/26 at 9:05 a.m., the Administrator said that he was not aware of missing cell phones and could not remember if Executive Director had reported this to him. He said when families or residents report missing personal items CNA Manager C immediately followed up on these concerns and usually most of the missing items were found.During an interview on 04/10/26 at 9:17 a.m., CNA Manager C revealed she assisted with trying to locate missing resident clothing and personal items and that 95% of the time the missing items were found. She said that usually reports of missing clothing and personal items such as phones are made to Executive Director by the families and/or staff, of missing items. She said she was not aware of the missing cell phone.During an interview on 04/10/26 at 9:45 a.m., the DON and LVN ADON D revealed that they did not remember anything about Resident #2 missing a cell phone. During an interview on 04/10/26 at 9:49 a.m., Receptionist B in the presence of the DON revealed that she had received a telephone call from someone at the dialysis center to report that Resident #2 had reported to them that he was missing his cell phone. Receptionist B said, I wrote it down on a sticky note and gave it to the nurse and did not remember who the nurse was and asked the nurse to give the note to CNA Manager C. She said she was not aware of the facility's policy and procedure on Grievances and was not aware that she needed to fill out a concern form when she received complaints/concerns related to missing items. She said that she did not know if they had found the resident's cell phone. She said that the resident's family had come to pick up the resident's belongings.During second interview on 04/10/26 at 9:58 a.m., the DON revealed she remembered she had received a call from the dialysis center and did not remember who she had talked to about Resident #2's concern related to his missing cell phone. She said she had not documented this in the resident's electronic clinical record.During an interview on 4/10/26 at 11:50 a.m., LVN I revealed Resident #2 was confused, lived [Country] and had been discharged home to his family member A home who lived in {Country]. She said that Resident #2 used to live with a family member B in [city] and that family member A could not come and visit due to not having a passport to come to the United States. She said that she remembered that the resident had lost his old cell phone on the weekend (continued on next page)

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 04/11/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and was never found. She said that the resident had poor vision and the staff would help him to dial the telephone numbers so he could call family member C and family member A. She said it was an old basic cell phone, and he was able to only use [App] to face time with his family member A all the time. She said resident was sad that he had lost his cell phone because he could no longer communicate with his family. She said she had not documented this in the resident's clinical record.Review of the facility's policy on Charting and Documentation revised in July 2017 provided by the Executive Director revealed, Policy Statement: All services provided to the resident, progress towards the care plan goals or any changes in resident's medical, physical function or psychological condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the residence condition and response to care. Policy Interpretation and Implementation: Documentation in the medical record may be electronic, manual, or a combination. The following information is to be documented in the resident medical records. Events, incidents or accidents involving the resident.