

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/17/2026
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	
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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that residents who required dialysis received such services, consistent with professional standards of practice for 1 of 5 (Resident #1) residents reviewed for quality of care, in that: The facility failed to maintain communication, coordination, and collaboration with the dialysis provider for Resident #1. This failure could place residents who received dialysis treatments at risk for complications and not receiving proper care and treatment to meet their needs. Findings included: Record review of Resident #1's face sheet dated 06/17/26 revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Record review of Resident #1's history and physical dated 05/16/26 revealed Resident #1 was admitted to the hospital on [DATE] with diagnoses which included acute on chronic renal failure (sudden worsening of already existing kidney disease), end stage renal disease (permanent kidney failure requiring dialysis or kidney transplant), acute metabolic acidosis (dangerous buildup of acid in the body due to the kidneys not removing waste properly), and metabolic encephalopathy (brain dysfunction caused by a medical condition affecting the body's normal balance). The history and physical revealed Resident #1 underwent placement of a hemodialysis catheter (a tube placed into a large vein that allows dialysis treatments to remove waste and excess fluid from the blood) and started hemodialysis (a treatment that filters waste and excess fluid from the blood when the kidneys can no longer do so adequately) during his hospitalization. Record review of Resident #1's initial MDS assessment dated [DATE] revealed a BIMS score of 15, indicating Resident #1 was cognitively intact. The assessment revealed Resident #1 was admitted to the facility on [DATE] following hospitalization. Record review from the MDS under section I, active diagnoses, revealed Resident #1 had diagnoses of renal insufficiency (decreased kidney function causing difficulty filtering waste and excess fluid from the blood), renal failure (the kidneys are no longer able to adequately remove waste and excess fluid from the body), or End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or kidney transplant). Section I revealed the resident was dependent on renal dialysis (requires routine dialysis treatments because the kidneys can no longer adequately filter waste and excess fluid from the blood). Record review of Resident #1's care plan dated 05/12/26 revealed Resident #1 received dialysis three times per week and was at risk for increased SOB (shortness of breath or difficulty breathing), chest pains, blood pressure changes, itchy skin, nausea and vomiting, impaired cognition (difficulty thinking, remembering, or making decisions), and infection to shunt site (infection at the dialysis access site used to access the bloodstream for dialysis treatments) and called for staff interventions on administering medications per order, monitoring labs and reporting abnormalities to MD, assessing shunt site before and after dialysis, and notifying MD of any abnormalities. The care plan revealed staff needed to monitor Resident #1's condition pre/post dialysis and report abnormalities to MD. Record review of the facility's PCC on 06/17/2026 at 10:43 a.m., for Resident #1 revealed there were no records of scanned hemodialysis communication forms into the system other than those for the appointments from 05/19/2026 and 06/11/2026. Review of the progress notes in PCC revealed there were no nursing notes entered into the system indicating the facility's staff communicated with the dialysis center to get any missing information for Resident #1's visit. Record review of Resident (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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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#1's dialysis communication forms for month of May and June 2026 revealed:-Resident #1's hemodialysis communication form dated 05/19/26 revealed pre-treatment vital signs of temperature 97.7 degrees Fahrenheit, pulse 80, respirations 16, and blood pressure 173/84. The post-treatment temperature, pulse, respirations, blood pressure, and weight sections were left blank. Dialysis center documentation indicated excessive fluid weight gain, mild restriction of one liter (32 ounces) of fluid intake, review of blood test results, and a request to review the medication list and phosphate binder orders with meals. The communication form did not contain documentation indicating facility follow-up regarding the dialysis center's recommendations.-Resident #1's hemodialysis communication form dated 06/11/26 revealed pre-treatment vital signs of temperature 98.6 degrees Fahrenheit, pulse 78, respirations 17, and blood pressure 127/91. The post-treatment temperature, pulse, respirations, blood pressure, and weight sections were left blank. Dialysis center documentation indicated fluid overload (excess fluid retained in the body), fluid restrictions of 1.5 liters per day, and dialysis treatment information. The communication form did not contain documentation indicating facility follow-up regarding the dialysis center's recommendations. During an interview on 06/17/2026 at 1:25 p.m., LVN A stated that upon a resident's return from dialysis, nursing staff were expected to obtain and document vital signs on the dialysis communication form and send the documentation to medical records. LVN A stated the dialysis communication form should be reviewed for changes in condition, medication changes, and new orders. LVN A stated that if dialysis documentation was incomplete or missing, staff were expected to contact the dialysis center and notify the DON. LVN A stated it was not acceptable for dialysis communication forms to be incomplete because a lack of communication between the dialysis center and the nursing facility could result in a failure to identify and follow up on a change in condition, placing the resident at risk. During an interview on 06/17/2026 at 1:50 p.m., LVN B stated that nursing staff were expected to complete the section of the dialysis communication form identified as 'Care Center Completes This Information' before the resident left for dialysis and again upon the resident's return. LVN B stated the dialysis communication form should include vital signs, dialysis access site information, and any changes in condition. LVN B stated that if information from the dialysis center was incomplete or missing, staff were expected to contact the dialysis center, request the missing information, and notify the DON. LVN B stated it was not acceptable for dialysis communication forms to be incomplete because important information regarding the resident's condition, including blood pressure changes and post-dialysis concerns, could be missed and not communicated to the facility. During an interview on 06/17/2026 at 2:18 p.m., the DON stated it was not acceptable that the dialysis communication forms did not contain post-dialysis vital signs after the resident returned from the dialysis center. The DON stated it was not acceptable that only two hemodialysis communication forms were available for review despite the resident residing at the facility for more than one month. The DON stated it was not acceptable to receive an incomplete dialysis communication form from the dialysis center and that the nurse receiving the resident back from dialysis was expected to contact the dialysis center and obtain the missing information. The DON confirmed there were no post-dialysis assessment progress notes documented in PCC and stated the facility should have documented vital signs and assessments in PCC following each dialysis appointment. The DON stated incomplete dialysis documentation could result in missing information, miscommunication between the dialysis center and the nursing facility, and the inability to identify and address a change in condition. During an interview on 06/17/2026 at 3:14 p.m., the RN Admin from the dialysis center stated that other nursing facilities routinely contacted the dialysis center when information was missing or clarification was needed regarding dialysis documentation. The RN Admin stated the current facility had not contacted the dialysis center regarding missing dialysis communication information. The RN Admin stated the dialysis communication forms were expected to be completed by both the dialysis center staff and the nursing facility staff to ensure continuity of care and communication regarding the resident's dialysis treatment. The RN Admin stated the forms should accurately document treatment (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	information, vital signs, fluid removal, medication changes, physician recommendations, changes in condition, and follow-up needs. The RN Admin stated incomplete or inaccurate documentation could result in missed physician recommendations, unaddressed changes in condition, delays in treatment, medication discrepancies, fluid management issues, miscommunication between the dialysis center and the nursing facility, and the inability of facility staff to make informed clinical decisions regarding the resident's care following dialysis treatment. Record review of the facility's in-service record dated 04/10/2026 revealed that RNs (Registered Nurses) and LVNs (Licensed Vocational Nurses) were trained on the hemodialysis communication form. The in-service stated that for each resident scheduled for dialysis, staff needed to complete the communication form, send the form with the resident for the procedure, and once the resident returned, staff were to complete information and add nursing notes into PCC including vital signs, dressing at shunt site, location of shunt, and any comments from the dialysis center. Record review of the facility's Hemodialysis Access Care policy revised on September 2019 revealed in part: The general medical nurse should document in the resident's medical record every shift as follows: 1. Location of catheter. 2. Condition of dressing (interventions if needed). 3. If dialysis was done during shift. 4. Any part of report from dialysis nurse post-dialysis being given. 5. Observations post-dialysis.		