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	07/11/2024

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34486 Based on interviews and record review the facility failed to develop a comprehensive person-centered care plan for each resident, that included measurable objectives and timeframes to meet a resident's medical needs that wase identified in the comprehensive assessment for 1 (Resident #40) of 20 residents reviewed for comprehensive person-centered care plans. The facility failed to develop a care plan that addressed Resident #40's diagnosis of diabetes. This failure could put residents at increased risk of not having their care needs met. Findings included: Record review of Resident #40's face sheet dated 07/10/2024 revealed he was [AGE] years old, initially admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #40's History and Physical dated 06/25/2024 revealed he had a diagnosis of kidney injury, and it was determined he would require dialysis. He had a diagnosis of diabetes mellitus and was taking medications for management of his diabetes. Record review of Resident #40's electronic diagnosis listing dated 07/10/2024 revealed he had a diagnosis of dependence on renal dialysis dated 6/24/2024. Record review of Resident #40's Admission MDS dated [DATE] revealed he had diagnoses including diabetes mellitus and was receiving insulin injections. Hemodialysis was not indicated on the MDS. Record review of Resident #40's Care Plan, revised 07/09/2024 revealed no care plan identifying diabetes as a focus of care or specifying goals or interventions to address his diagnosis of diabetes. No care plan identifying renal dialysis as a focus of care or specifying goals or interventions to address dialysis was found. In an interview on 07/11/24 at 08:49 AM the MDS nurse revealed diabetes should be on Resident #40's care plan. She said she could not identify a risk to the resident because nurses followed the MAR so they would be monitoring the resident's condition. (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 07/11/2024

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/11/24 at 02:14 PM the DON revealed Resident #40 should have a care plan for diabetes. She said the purpose of a care plan was to monitor the patient's condition, to track changes and responses to interventions. She said if this was not included on the care plan there should not be a problem because the MAR documented that the resident's blood sugar was being monitored so the resident was getting the care he needed. A policy regarding care planning was requested. The policies received did not address comprehensive care plans. 45411

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45411 Based on interviews and record review, the facility failed to ensure dialysis services were provided consistently with professional standards of practice for 2 (Resident #7 and Resident #40) of 2 residents reviewed for dialysis services. The facility failed to ensure post-dialysis (treatment that filters water and waste from the blood when the kidneys are no longer able to do so) assessments were documented in Resident #7 and Resident #40's charts. These failures could place residents who received dialysis at risk for complications and not receiving proper care and treatment to meet their needs. Findings included: Resident #7 Review of Resident #7's Admission Record, dated 7/10/24, revealed she was a [AGE] year-old female originally admitted to the facility 5/20/19 with a most recent admitted [DATE]. She had diagnoses which included dementia with behavior disturbances, end stage renal disease (condition in which the kidneys permanently stop working and can no longer perform their essential functions) with dependence on hemodialysis (treatment that filters water and waste from the blood when the kidneys are no longer able to do so), major depressive disorder, generalized anxiety disorder, and type 2 diabetes mellitus. Review of Resident #7's Annual MDS Assessment, dated 5/24/24, revealed she was receiving PASARR (Preadmission Screening and Resident Review) services for intellectual disability, she had a BIMS (Brief Interview for Mental Status) score of 2 indicating severe cognitive impairment with inattention, she used a wheelchair for mobility, and required maximum assistance or was dependent on staff for all ADLs except for eating. She received antipsychotic medication and antiplatelet medication. She received hemodialysis, speech therapy, occupational therapy, and physical therapy. Review of Resident #7's Care Plan, most recent revision 6/25/24, revealed the following: Focus - Impaired renal function: I receive dialysis three times per week and at risk for increased SOB (shortness of breath), chest pains, blood pressure, itchy skin, nausea and vomiting, impaired cognition, infection to shunt (a surgically created connection between an artery and a vein that allows a dialysis machine to access the bloodstream for hemodialysis) site, and decreased urine output. Goal - Will have no complications or infected shunt site through next review date. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interventions - Administer medications per order - monitor labs and report abnormalities to MD. Assess shunt site before and after dialysis - notify MD of any abnormalities. Auscultate (listen with a stethoscope) bruit (sound heard over an artery reflecting the turbulence of blood flow) to shunt every shift. Do not take BP on extremity of shunt site. Ensure resident is aware of dietary recommendations/restrictions r/t disease process. If bleeding noted from shunt site apply pressure until bleeding subsides and notify MD. Monitor resident condition pre/post dialysis, report abnormalities to MD. Monitor/assess shunt site for s/sx of infection, bleeding, etc., every shift - notify MD. Provide assist with ADLs and comfort measures as needed. Serve diet per order - monitor intake. Provide sack lunch as needed. Focus - Resident is dependent on dialysis Monday, Wednesday, and Friday r/t ESRD (End Stage Renal Disease). Goal - The resident will have no s/sx of complications from dialysis through the review date. Interventions - Monitor shunt for bleeding every hour for the first 4 hours upon return from dialysis center, report changes to NP/MD, document findings in nurses' notes. Check dialysis shunt for bruit and thrill (a vibration that can be felt on the skin over a blood vessel) every shift and report changes to NP/MD (redness, swelling, irritation, uncontrolled bleeding and change in bruit and thrill). Do not take BP or lab draws in right arm r/t fistula (an abnormal connection between two parts of the body) in place. Encourage resident to go for the scheduled dialysis appointments - resident receives dialysis (Monday, Wednesday, and Friday). Monitor labs and report to doctor as needed. Monitor/document/report PRN any s/sx of infection to access site: redness, swelling, warmth, or drainage. Monitor/document/report PRN for s/sx of renal insufficiency: changes in level of consciousness, changes in skin turgor, oral mucosa (soft tissue lining of the mouth), changes in heart, and lung sounds. Monitor/document/report PRN for s/sx of the following: bleeding, hemorrhage (bleeding from a ruptured blood vessel), bacteremia (bacteria in the blood), septic shock (bacterial infection causing dangerously low blood pressure, organ failure, and widened blood vessels). Send snack with her to dialysis. Review of Resident #7's Order Summary Report, dated 7/10/24, revealed the following: Check dialysis shunt for bruit and thrill every shift and report changes to NP/MD (redness, swelling, irritation, uncontrolled bleeding, and change in bruit and thrill) - every shift (Order Date 12/8/23) Monitor dressing to perm-a-cath (flexible tube that can be used for a variety of medical procedures including dialysis) site every shift, report changes to NP/MD - every shift (Order Date 12/8/23) Monitor shunt for bleeding every hour for the first 4 hours upon return from dialysis center, report changes to NP/MD, document findings in nurses' notes - in the afternoon every Monday, Wednesday, and Friday (Order Date 12/8/23) No venipuncture (blood draw) or blood pressure to right upper extremity (right arm) with dialysis access - every shift (Order Date 4/4/24) (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident to be dialyzed every Monday-Wednesday-Friday, provide resident with a packed meal, report changes to NP/MD (ex: resident misses dialysis on scheduled days) - Chair time is 9:00 (Order Date 12/8/23) Observation and record review on 7/10/24 at 4:05 pm of 100/200 Hall Dialysis Communication binder revealed 17 communication sheets dating back to May 2024. Two of the sheets had the name of a discharged resident. Of the remaining 15 sheets, 5 had no resident name or identifier to indicate which resident they belonged to and the other 10 had Resident #7's name on them. The forms that had no resident identifier (name, birthdate, identification number) where completed by both the facility nurse and the dialysis center nurse. Review of facility form Hemodialysis Communication revealed the form contained a section for date of service, vital signs, pain assessment, vascular access type and site, and any changes with the resident since the last treatment to be communicated to the dialysis center, as well as a section for nurse signature/date/time. The form also contained a section to be completed by the dialysis center nurse regarding medications given during treatment, order changes, follow-ups, and any occurrences during the treatment, as well as a section for nurse signature/date/time. Record review on 7/10/24 at 4:10 pm of Resident #7's electronic chart progress notes section revealed no post-dialysis documentation in nurses notes for the months of May 2024, June 2024, and July 2024. Observation and interview on 7/10/24 at 3:45 pm Resident #7 was observed sitting in her wheelchair by the nurses station on the 100/200 Hall. Two flesh-colored bandages were noted to the resident's right upper arm at her dialysis access site. When asked if she went to dialysis that morning, Resident #7 stated yes and smiled. When asked if her arm was still bleeding when she returned to the facility she stated yes and held her right arm out and pointed to the bandages. Resident #7 denied pain to the site. When asked if the bandages were placed on her arm at the dialysis center, she shook her head side to side and stated no, here. The State Surveyor clarified by asking if the nurse put the bandage on her arm when she got home and Resident #7 stated yes. Resident #40 Review of Resident #40's Admission Record, dated 7/11/24, revealed he was an [AGE] year-old male originally admitted to the facility on [DATE] with a most recent admitted [DATE]. He had diagnoses which included chronic kidney disease (longstanding disease of the kidneys leading to kidney failure) with dependence on renal dialysis (treatment that filters water and waste from the blood when the kidneys are no longer able to do so), type 2 diabetes mellitus, history of heart attack, and anemia. Review of Resident #40's Medicare 5-Day MDS Assessment, dated 6/30/24, revealed a BIMS (Brief Interview for Mental Status) score of 6 indicating severe cognitive impairment, he required moderate to maximum assistance for most ADLs, but was dependent on staff for toileting, bathing, and dressing. e required a wheelchair for mobility. He received hemodialysis. Review of Resident #40's Care Plan, most recent revision date 7/6/24, revealed no care plan in place for dialysis. Review of Resident #40's Order Summary Report, dated 7/11/224, revealed the following: (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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Check dialysis catheter to right upper chest every shift and report changes to NP/MD (redness, swelling, irritation, uncontrolled bleeding and change in bruit (sound heard over an artery reflecting the turbulence of blood flow) and thrill (a vibration that can be felt on the skin over a blood vessel) - every shift (Order Date 6/24/24) Check dialysis catheter to right upper chest every shift for bleeding and report changes to NP/MD (redness, swelling, irritation, uncontrolled bleeding, etc.) - every shift (Order Date 6/24/24) No venipuncture (blood draw) or blood pressure to right upper extremity (right arm) with dialysis access - every shift (Order Date 6/24/24) Resident to be dialyzed every Monday-Wednesday-Friday. Provide resident with a packed meal. Report changes to NP/MD (ex: resident misses dialysis on scheduled days) every shift, every Monday, Wednesday, Friday (Order Date 6/24/24) Record review on 7/11/24 at 4:28 pm of 300/400/500 Hall Dialysis Communication Binder revealed no Hemodialysis Communication forms for Resident #40. The binder contained only blank forms. Record review on 7/11/24 at 4:40 pm of Resident #40's electronic chart progress notes section revealed no post-dialysis documentation in nurses notes since his readmission to the facility on [DATE]. Review of the facility form Hemodialysis Communication on 7/10/24 at 4:05 pm revealed the form contained a section for date of service, vital signs, pain assessment, vascular access type and site, and any changes with the resident since the last treatment to be communicated to the dialysis center, as well as a section for nurse signature/date/time. The form also contained a section to be completed by the dialysis center nurse regarding medications given during treatment, order changes, follow-ups, and any occurrences during the treatment, as well as a section for nurse signature/date/time. In an interview on 7/10/24 at 4:19 pm, the ADON stated he believed there were currently only two residents in the facility on dialysis, but he needed to check in the computer. The ADON verified in the computer that there were, in fact, only two residents receiving dialysis: Resident #7 on 100 hall and Resident #40 on 300 hall. He stated that the nurses were supposed to document on the MAR when doing shunt site checks and monitoring vitals before and after the resident goes to dialysis. The ADON stated he had completed the assessments himself and knew the other nurses were completing them because he had observed them when they (the assessments) were done. He stated Resident #7's order did say to document the site check in a nurses note but he was unsure if that meant for every site check or just if there were issues. The ADON stated that after rereading it, he believed the order was for any exception to her regular status not to document each time. He stated he was uncertain of Resident #40's orders and would review them. He stated that the facility used the communications sheets and the MAR as their pre- and post-dialysis monitoring for residents. In an interview on 7/10/24 at 4:30 pm, the DON stated the nurses should have been documenting something in a progress note when a resident returned to the facility from receiving dialysis, not just using the communication sheets and the MAR. She stated she knew the nurses were completing assessments on the residents when they returned from dialysis because she had witnessed them being performed. She stated she was new to the position of DON, and she did not know what the facility policy was for documenting when a resident returned from dialysis, but she stated that the current documentation did appear lacking. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility policy titled Hemodialysis Catheters - Access and Care of, revision date February 2023, revealed, in part: Care Immediately Following Dialysis Treatment: 1. The dressing change is done in the dialysis center post-treatment. 2. If the dressing becomes wet, dirty, or not intact, the dressing shall be changed by a licensed nurse trained in this procedure. 3. Mild bleeding from site (post-dialysis) can be expected. Apply pressure to insertion site and contact the dialysis center for instructions. 4. If there is major bleeding from site (post-dialysis), apply pressure to the insertion site, and contact emergency services and the dialysis center. Verify that clamps are closed on lumens. This is a medical emergency. Do not leave resident alone until emergency services arrive. The policy did not address documentation of pre/post-dialysis assessments.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34486 Based on interviews and record review, the facility failed to ensure drug regimen irregularities reported by the Pharmacist Consultant were acted upon by the physician for 1 (Resident #3) of 6 residents reviewed for physician response to medication regimen review. The facility failed to ensure that the physician responded to Pharmacist Consultant recommendations that an appropriate diagnosis or gradual dose reduction be applied to Risperidone [Risperdal] (an antipsychotic medication) prescribed for Resident #3. This failure could place residents at risk of adverse side effects and decreased quality of life as a result of receiving unnecessary antipsychotic medications. Findings included: Record review of Resident #3's face sheet revealed she was [AGE] years old and was initially admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #3's history and physical dated 11/19/2023 revealed she had diagnoses including dementia. She was sent to a geriatric behavioral unit for being erratic, combative, and having violent behaviors. She had diagnoses including exacerbation of major depressive disorder, and dementia with behavioral disturbances. She was to continue receiving Risperidone for her diagnosis of dementia with behavioral disturbance. Record review of Resident #3's annual MDS assessment dated [DATE] revealed she had a BIMS score of 2 (severe cognitive impairment). She had no symptoms of delirium or psychosis and had no behavioral symptoms over the seven days before the assessment. Her active diagnoses included non-Alzheimer's dementia, anxiety disorder, and depression. She had received antipsychotic and antidepressant medication during the seven days before the assessment. She was receiving antipsychotics on a routine basis and no GDRs had been attempted. The physician had not documented that the GDR was clinically contraindicated. Record review of Resident #3's physician's order dated 01/23/2024 revealed she was to be administered 0. 25 MG of Risperidone at bedtime for behavioral disturbance. Record review of Resident #3'a MAR for May 2024 revealed she was administered 0.25 MG of Risperidone at bedtime every day for behavioral disturbance. Record review of Resident #3'a MAR for June 2024 revealed she was administered 0.25 MG of Risperidone at bedtime every day for behavioral disturbance. Record review of Resident #3'a MAR for July 2024 dated 07/10/2024 revealed she was administered 0.25 MG of Risperidone daily at bedtime for behavioral disturbance from 07/01/2024 through 07/09/2024. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #3's pharmacy review note to Attending Physician/Prescriber dated 1/19/2024 revealed a note to the physician indicating that the conditions indicated for use of Risperdal, an antipsychotic, including unspecified dementia with behavioral disturbances, insomnia unspecified, and major depressive disorder, recurrent moderate, did not justify the use of an antipsychotic. Based on the physician's note, the resident's dosage of Risperdal was decreased, but diagnoses were not changed. Record review of Resident #3's pharmacy review note to Attending Physician/Prescriber dated 03/29/2024 revealed a note to the physician regarding Resident #3 indicating that her Risperdal was due for GDR and recommended reducing Risperdal 0.25 MG to 0.125 MG. A facility follow-through comment stated that a note was written to the secondary physician. Record review of Resident #3's pharmacy review note to Attending Physician/Prescriber dated 04/30/2024 revealed a note to the physician indicating that Risperdal was presented for GDR the month before along with another suggested medication change (reduce Trazodone 150mg half tablet) and neither were changed. The pharmacy review note recommended that the physician consider reducing Risperdal to 0.25 MG to PRN for 14 days and then discontinuing it. The pharmacy review also noted that Risperdal did not currently carry an appropriate indication for the setting [nursing facility]. No response to the pharmacy recommendation was noted. Record review of Resident #3's pharmacy review note to Attending Physician/Prescriber dated 05/16/2024 revealed a note to the physician indicating that Risperdal 0.25 MG was not properly indicated to continue at this time and to please discontinue the medication to comply with current regulations. The pharmacy review recommendation was signed on 6/6/2024 indicating the signer disagreed with the recommendation. No justification for disagreeing with the recommendation was written on the physician's note. In an interview on 07/11/24 at 02:17 PM the DON revealed that Resident #3 should not be prescribed Risperidone for behavioral disturbance, because it was an inappropriate diagnosis. She stated that she had not had an opportunity to audit medications due to her recent arrival, that the medication was prescribed before she took the position as the DON, so she had not seen it. She said that when the pharmacy recommendations were received the physician would be notified. In the case of Resident #3's pharmacy recommendation it had been reviewed by the nurse practitioner, but no change had been made to the prescription. The DON said recommendations regarding antipsychotics might be made to prevent their overuse, that there were concerns that antipsychotics might be used as chemical restraints, that they could have side effects such as dyskinesia (uncontrolled, involuntary muscle movements), and neurological defects. She stated she was aware of black box warning that antipsychotics should not be used for older adults with dementia. She stated that the prescriber should indicate on the Pharmacy Recommendation why recommended changes were denied. Record review of the facility policy Antipsychotic Medication Use revised 07/2022 revealed that residents would not receive medications that were not clinically indicated to treat a specific condition for which they were indicated and effective. Physicians would respond by clear documentation based on assessment why the benefits of the medication outweighed the risks. A policy regarding Consultant Pharmacy reviews was requested in an e-mail to the facility Administrator-in-Training but was not received prior to exit.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34486 Based on interviews and record review the facility failed to ensure that residents who have not used psychotropic drugs were not given these drugs unless the medication was necessary to treat a specific condition as diagnosed and documented in the clinical record for 2 (Residents #3 and #7) of 8 residents reviewed for unnecessary medications, and failed to ensure PRN orders for psychotropic drugs were limited to 14 days for 1 (Resident #98) of 8 residents reviewed for unnecessary medications. The facility failed to ensure that Resident #7 and Resident #3 had appropriate diagnoses for Risperidone (an antipsychotic used to treat schizophrenia and bipolar disorder). The facility failed to ensure that Resident #98 had a 14-day limit on her order for PRN Lorazepam. These failures put residents at increased risk for adverse consequences such as impairment or decline in an individual's mental or physical condition or functional or psychosocial status from receiving unnecessary antipsychotic medications. The findings included: Resident #98 Record review of Resident #98's face sheet dated 07/10/2024 revealed she was [AGE] years old, initially admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident # 98's history and physical dated 07/01/2024 revealed she had diagnoses including Parkinson's disease history of deep vein thrombosis (blood clots in the leg), pulmonary embolism (blood clot in the lung), and was receiving hospice care. Record review of Resident #98's Admission MDS assessment dated [DATE] revealed she had a BIMS score of 12 (moderate cognitive impairment). She had no symptoms of delirium, psychosis, and no behavioral symptoms. She had diagnoses including non-Alzheimer's dementia, Parkinson's disease, seizure disorder or epilepsy, and depression. She was taking an antipsychotic, and an antidepressant. Record review of Resident # 98's care plan dated 6/30/2024 revealed she was at risk of adverse consequences from taking antipsychotic medication (quetiapine). Her care plan dated 6/30/2024 revealed she had a diagnosis of depression/bipolar disorder and was at risk for fluctuation in moods, little interest, or pleasure in doing things, decreased socialization, and was currently receiving Mirtazapine (an antidepressant). Her care plan dated 6/30/2024 revealed she had episodes of anxiety, was at risk for fluctuation in moods, and was taking lorazepam (an anti-seizure and anti-anxiety medication). Record review of Resident # 98's physician's order for Lorazepam Oral Concentrate 2 MG/ML (Lorazepam) revealed she was to receive an application by mouth every four hours as needed for anxiety/restlessness. No end date for the as-needed order was indicated. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #98's June and July MARs revealed that she had never been administered Lorazepam Oral Concentrate 2 MG/ML . In an interview on 07/11/24 at 02:04 PM the DON revealed that Lorazepam prescribed for Resident #98 and other anxiolytics (medicines to treat anxiety) were psychotropic medications and that regulations put a 14-day limit on PRN psychotropics. She stated that she audited resident charts on admission and as needed to confirm psychotropic medications were ordered appropriately. She said the 14-day limit on psychotropic medications were in place to ensure that the patient was tolerating the medication and to see if the medication was effective. She said the 14-day limit on PRN psychotropic medications also helped prevent overuse of the medications. She pointed out that the medication had been prescribed for the resident as a comfort measure because the resident was in hospice but acknowledged that the facility was responsible for what the hospice did when providing services to facility residents. Review of Resident #7's Admission Record, dated 7/10/24, revealed she was a [AGE] year-old female originally admitted to the facility 5/20/19 with a most recent admitted [DATE]. She had diagnoses which included dementia with behavior disturbances, end stage renal disorder with dependence on dialysis, major depressive disorder, generalized anxiety disorder, and type 2 diabetes mellitus. Review of Resident #7's Annual MDS Assessment, dated 5/24/24, revealed she was receiving PASARR services for intellectual disability, she had a BIMS score of 2 indicating severe cognitive impairment with inattention, she used a wheelchair for mobility, required maximum assistance, or was dependent on staff for all ADLs except for eating. She received antipsychotic medication and antiplatelet medication. An antipsychotic GDR was documented as clinically contraindicated on 7/1/22. She received hemodialysis, speech therapy, occupational therapy, and physical therapy. Review of Resident #7's Care Plan, most recent revision 6/25/24, revealed the following: Focus - Resident uses psychotropic medication Risperidone as ordered. Goal - The resident will be/remain free of psychotropic drug related complications including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction, or cognitive/behavioral impairment through the review date. (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 07/11/2024
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 0758

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Interventions - Antipsychotic Medication - Monitor for dry mouth, constipation, blurred vision, disorientation/confusion, difficulty urinating, hypotension, dark urine, yellow skin, N/V, lethargy, drooling, EPS symptoms (tremors, disturbed gait, increased agitation, restlessness, involuntary movement of mouth or tongue). Document: Y if monitored and none of the above observed, N if monitored and any of the above was observed, select chart code Other/See Nurses Notes and progress note findings. Behaviors - Monitor for the following: itching, picking at skin, restlessness (agitation), hitting, increase in complaints, biting, kicking, spitting, cussing, racial slurs, elopement, stealing, delusions, hallucinations, psychosis, aggression, refusing care - Document N if monitored and none of the above observed, Y if monitored and any of the above observed, select chart code Other/See Nurses Notes and progress note findings. Administer Psychotropic medications as ordered by physician - monitor for side effects and effectiveness. Consult with pharmacy and MD to consider dosage reduction when clinically appropriate at least quarterly. Monitor/document/report PRN any adverse reactions of psychotropic medications: unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps, vomiting, behavior symptoms not usual to the person.

Review of Resident #7's most recent Psychiatric Follow Up Evaluation, dated 5/19/24, revealed Psychiatric Diagnosis: 1. Unspecified dementia without behavioral disturbances; 2. Major depressive disorder, recurrent, moderate; 3. Anxiety unspecified. Psychiatric Treatment Plan: Continue risperidone 0.5 mg BID for dementia and aggressive behaviors.

Review of Resident #7's Order Summary Report, dated 7/10/24, revealed the following:

Antipsychotic Medication - Monitor for dry mouth, constipation, blurred vision, disorientation/confusion, difficulty urinating, hypotension, dark urine, yellow skin, N/V, lethargy, drooling, EPS symptoms (tremors, disturbed gait, increased agitation, restlessness, involuntary movement of mouth or tongue). Document: Y if monitored and none of the above observed, N if monitored and any of the above was observed, select chart code Other/See Nurses Notes and progress note findings - every shift (Order Date 12/11/23)

Risperidone oral tablet 0.5 mg: give one tablet by mouth two times a day for impulsive disorder (Order Date 12/14/23).

Review of Resident #7's MAR on 7/10/24 revealed that in the months of May 2024, June 2024, and July 2024, she received risperidone 0.5mg twice a day as ordered.

Resident #3

Record review of Resident #3's face sheet revealed she was [AGE] years old, was initially admitted to the facility on [DATE] and readmitted on [DATE].

Record review of Resident #3's history and physical dated 11/19/2023 revealed she had diagnoses including dementia. She was sent to a geriatric behavioral unit for being erratic, combative, and having violent behaviors. She had diagnoses including exacerbation of major depressive disorder, and dementia with behavioral disturbances. She was to continue receiving Risperidone for her diagnosis of dementia with behavioral disturbance.

(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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #3's annual MDS assessment dated [DATE] revealed she had a BIMS score of 2 (severe cognitive impairment). She had no symptoms of delirium or psychosis and had no behavioral symptoms over the seven days before the assessment. Her active diagnoses included non-Alzheimer's dementia, anxiety disorder, and depression. She had received antipsychotic and antidepressant medication during the seven days before the assessment. She was receiving antipsychotics on a routine basis and no GDRs had been attempted. The physician had not documented that GDR was clinically contraindicated. Record review of Resident #3's physician's order dated 01/23/2024 revealed she was to be administered 0. 25 MG of Risperidone at bedtime for behavioral disturbance. Record review of Resident #3'a MAR for May 2024 revealed she was administered 0.25 MG of Risperidone at bedtime every day for behavioral disturbance. Record review of Resident #3'a MAR for June 2024 revealed she was administered 0.25 MG of Risperidone at bedtime every day for behavioral disturbance. Record review of Resident #3'a MAR for July 2024 dated 07/10/2024 revealed she was administered 0.25 MG of Risperidone daily at bedtime for behavioral disturbance from 07/01/2024 through 07/09/2024. Record review of Resident #3's pharmacy review Note to Attending Physician/Prescriber dated 1/19/2024 revealed a note to the physician indicating that the conditions indicated for use of Risperdal, an antipsychotic, including Unspecified Dementia with behavioral disturbances, insomnia unspecified, and Major Depressive Disorder, recurrent moderate, did not justify the use of an antipsychotic. Based on the physician's note, the resident's dosage of Risperdal was decreased, but diagnoses were not changed. Record review of Resident #3's pharmacy review Note to Attending Physician/Prescriber dated 03/29/2024 revealed a note to the physician regarding Resident #3 indicating that her Risperdal was due for DGR and recommended reducing Risperdal 0.25 to 0.125 MG. A facility follow-though comment stated that a note was written to the secondary physician. Record review of Resident #3's pharmacy review Note to Attending Physician/Prescriber dated 04/30/2024 revealed a note to the physician indicating that Risperdal was presented for GDR the month before along with another suggested medication change (reduce Trazodone 150mg half tablet) and neither were changed. The pharmacy review note recommended that the physician consider reducing Risperdal to 0.25 MG to PRN for 14 days and then discontinuing it. The pharmacy review also noted that Risperdal did not currently carry an appropriate indication for the setting [nursing facility]. No response to the pharmacy recommendation was noted. Record review of Resident #3's pharmacy review Note to Attending Physician/Prescriber dated 05/16/2024 revealed a note to the physician indicating that Risperdal 0.25 was not properly indicated to continue at this time and to please discontinue the medication to comply with current regulations. The pharmacy review recommendation was signed on 6/6/2024 indicating the signer disagreed with the recommendation. No justification for disagreeing with the recommendation was written on the physician's note. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 07/11/24 at 02:17 PM the DON revealed that Resident #3 should not be prescribed Risperidone for behavioral disturbance, because it was an inappropriate diagnosis. She stated that she had not had an opportunity to audit medications due to her recent arrival, that the medication was prescribed before she took the position as DON so she had not seen it. She said that when pharmacy recommendations were received the physician would be notified. In the case of Resident #3's pharmacy recommendation it had been reviewed by the nurse practitioner, but no change had been made to the prescription. The DON said recommendations regarding antipsychotics might be made to prevent their overuse, that there were concerns that antipsychotics might be used as chemical restraints, that they could have side effects such as dyskinesia (uncontrolled, involuntary muscle movements), and neurological defects. She stated she was aware of black box warning that antipsychotics should not be used for older adults with dementia. She stated that the prescriber should indicate on the Pharmacy Recommendation why recommended changes were denied. Record review of the facility policy Antipsychotic Medication Use revised 07/2022 revealed that residents would not receive medications that were not clinically indicated to treat a specific condition for which they were indicated and effective. Physicians would respond by clearly documentation based on assessment why the benefits of the medication outweighed the risks. 45411

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45411 Based on observations, record review, and interviews, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for food procurement. 1. The facility failed to ensure foods were properly labeled (contents of containers, opened date, date prepared), covered, and sealed. 2. The facility failed to ensure meat was thawed properly on a tray in the refrigerator. These failures could place residents who ate food from the kitchen at risk of food borne illness and disease. Findings Included: Observation and interview on 7/9/24 at 8:18 am with [NAME] C, revealed an unsealed plastic bag labeled cilantro found in the refrigerator labeled Produce. [NAME] C stated the risk of having the bag open and not inside a sealed bag was that there was no way to know when it had been opened. [NAME] C stated that cilantro was perishable and if it was used to cook, there was a potential to make the residents sick. A clear plastic container with no lid and no label containing red fruit was found inside the same refrigerator. The fruit in the container appeared overripe and mushy. [NAME] C stated that the same risks were present for having the fruit uncovered and unlabeled. He stated there was no way to know when they were placed in the refrigerator and if they were given to the residents and were spoiled, the residents could get sick. Observation and interview on 7/9/24 at 8:27 am with [NAME] C revealed, two briskets (wrapped in original plastic with label) on the bottom (floor) of the refrigerator, thawing, with meat juices and blood pooling around them onto the bottom of refrigerator labeled Raw. [NAME] C stated that the meat was not supposed to be thawed like that. He stated that the process to thaw meat was to move it from the freezer to the refrigerator 3 days before they cook the meat. He statedthey place it on a metal tray in case there were juices or blood drippings, so they fell into the metal tray and not into the refrigerator. He stated that the risk of the drippings falling into the fridge was that they could contaminate the food and create bacteria that could make the residents sick. Observation and interview on 7/9/24 at 8:40 am with the Registered Dietician revealed, inside the refrigerator labeled Dairy, a bottle of ranch dressing was found with dry dressing dripping outside the lid. The Registered Dietitian stated that by having dried food particles there was a possibility of spoiling the food items near the bottle or that it could attract pests. A clear plastic container labeled tomato sauce was found in the same refrigerator with a plastic cling-wrap cover that was not secured or sealed. The Registered Dietician stated that there was a risk of the tomato sauce spoiling because it was not properly sealed or that if it was to fall, the contents of the container could spill inside the refrigerator, creating a contamination issue. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 7/10/24 at 11:45 am with the Dietary Director, she stated that the meat found thawing in the refrigerator should have had a tray under it. She stated that refrigerator was only used for raw foods to be thawed out before they were cooked but the liquid could have soaked into boxes or other foods surrounding it. She stated that she did not believe there was a resident outcome from not having a tray under the thawing meat. She stated that the fruit found uncovered in the refrigerator should have had a lid with a label and a date. She stated that when she looked at the fruit some of it was still edible, but some was mushy in appearance. She stated the resident outcome was a lack in flavor, and possible contamination of the fruit from being left uncovered. She stated that the tomato sauce and the ranch dressing were both at risk of contamination due to not being properly sealed which could put residents at risk of becoming sick. She stated that the fruit, tomato sauce, and ranch dressing had all been disposed of when they were discovered. Review of facility policy titled Food Receiving and Storage, revision date November 2022, revealed, in part: All foods stored in the refrigerator or freezer are covered, labeled, and dated (use by date). Uncooked and raw animal products and fish are stored separately in drip-proof containers and below fruits, vegetables and other ready-to-eat foods to prevent meat juices from dripping onto these foods.

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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 - Few	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** 45411 Based on observations, interviews, and record review the facility failed to maintain clinical records that were complete and accurate for 1 of 4 (Resident #7) residents reviewed for clinical records. The facility failed to place resident identifying information on 5 of 17 Hemodialysis Communication forms located in the 100/200 Hall Dialysis (treatment that filters water and waste from the blood when the kidneys are no longer able to do so) Communication Binder. The facility failed to ensure that Resident #7's Hemodialysis Communication forms were scanned into her electronic chart as part of her permanent record and post-dialysis monitoring. This failure could place residents at risk for inadequate monitoring and inaccurate records. The findings were: Review of Resident #7's Admission Record, dated 7/10/24, revealed she was a [AGE] year-old female originally admitted to the facility 5/20/19 with a most recent admitted [DATE]. She had diagnoses which included dementia with behavior disturbances, end stage renal disease (condition in which the kidneys permanently stop working and can no longer perform their essential functions) with dependence on hemodialysis (treatment that filters water and waste from the blood when the kidneys are no longer able to do so), major depressive disorder, generalized anxiety disorder, and type 2 diabetes mellitus. Review of Resident #7's Annual MDS Assessment, dated 5/24/24, revealed she was receiving PASARR (Preadmission Screening and Resident Review) services for intellectual disability, she had a BIMS (Brief Interview for Mental Status) score of 2 indicating severe cognitive impairment with inattention, she used a wheelchair for mobility, and required maximum assistance or was dependent on staff for all ADLs except for eating. She received antipsychotic medication and antiplatelet medication. She received hemodialysis, speech therapy, occupational therapy, and physical therapy. Review of Resident #7's Care Plan, most recent revision 6/25/24, revealed the following: Focus - Impaired renal function: I receive dialysis three times per week and at risk for increased SOB (shortness of breath), chest pains, blood pressure, itchy skin, nausea and vomiting, impaired cognition, infection to shunt (a surgically created connection between an artery and a vein that allows a dialysis machine to access the bloodstream for hemodialysis) site, and decreased urine output. Goal - Will have no complications or infected shunt site through next review date. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interventions - Administer medications per order - monitor labs and report abnormalities to MD. Assess shunt site before and after dialysis - notify MD of any abnormalities. Auscultate (listen with a stethoscope) bruit (sound heard over an artery reflecting the turbulence of blood flow) to shunt every shift. Do not take BP on extremity of shunt site. Ensure resident is aware of dietary recommendations/restrictions r/t disease process. If bleeding noted from shunt site apply pressure until bleeding subsides and notify MD. Monitor resident condition pre/post dialysis, report abnormalities to MD. Monitor/assess shunt site for s/sx of infection, bleeding, etc., every shift - notify MD. Provide assist with ADLs and comfort measures as needed. Serve diet per order - monitor intake. Provide sack lunch as needed. Focus - Resident is dependent on dialysis Monday, Wednesday, and Friday r/t ESRD (End Stage Renal Disease). Goal - The resident will have no s/sx of complications from dialysis through the review date. Interventions - Monitor shunt for bleeding every hour for the first 4 hours upon return from dialysis center, report changes to NP/MD, document findings in nurses' notes. Check dialysis shunt for bruit and thrill (a vibration that can be felt on the skin over a blood vessel) every shift and report changes to NP/MD (redness, swelling, irritation, uncontrolled bleeding and change in bruit and thrill). Do not take BP or lab draws in right arm r/t fistula (an abnormal connection between two parts of the body) in place. Encourage resident to go for the scheduled dialysis appointments - resident receives dialysis (Monday, Wednesday, and Friday). Monitor labs and report to doctor as needed. Monitor/document/report PRN any s/sx of infection to access site: redness, swelling, warmth, or drainage. Monitor/document/report PRN for s/sx of renal insufficiency: changes in level of consciousness, changes in skin turgor, oral mucosa (soft tissue lining of the mouth), changes in heart, and lung sounds. Monitor/document/report PRN for s/sx of the following: bleeding, hemorrhage (bleeding from a ruptured blood vessel), bacteremia (bacteria in the blood), septic shock (bacterial infection causing dangerously low blood pressure, organ failure, and widened blood vessels). Send snack with her to dialysis. Review of Resident #7's Order Summary Report, dated 7/10/24, revealed the following: Check dialysis shunt for bruit and thrill every shift and report changes to NP/MD (redness, swelling, irritation, uncontrolled bleeding, and change in bruit and thrill) - every shift (Order Date 12/8/23) Monitor dressing to perm-a-cath (flexible tube that can be used for a variety of medical procedures including dialysis) site every shift, report changes to NP/MD - every shift (Order Date 12/8/23) Monitor shunt for bleeding every hour for the first 4 hours upon return from dialysis center, report changes to NP/MD, document findings in nurses' notes - in the afternoon every Monday, Wednesday, and Friday (Order Date 12/8/23) No venipuncture (blood draw) or blood pressure to right upper extremity (right arm) with dialysis access - every shift (Order Date 4/4/24) (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident to be dialyzed every Monday-Wednesday-Friday, provide resident with a packed meal, report changes to NP/MD (ex: resident misses dialysis on scheduled days) - Chair time is 9:00 (Order Date 12/8/23) Observation and interview on 7/10/24 at 3:45 pm Resident #7 was observed sitting in her wheelchair by the nurses station on the 100/200 Hall. Two flesh-colored bandages were noted to the resident's right upper arm at her dialysis access site. When asked if she went to dialysis that morning, Resident #7 stated yes and smiled. When asked if her arm was still bleeding when she returned to the facility she stated yes and held her right arm out and pointed to the bandages. Resident #7 denied pain to the site. When asked if the bandages were placed on her arm at the dialysis center, she shook her head side to side and stated no, here. The State Surveyor clarified by asking if the nurse put the bandage on her arm when she got home and Resident #7 stated yes. Observation and record review on 7/10/24 at 4:05 pm of 100/200 Hall Dialysis Communication binder revealed 17 communication sheets dating back to May 2024. Two of the sheets had the name of a discharged resident. Of the remaining 15 sheets, 5 had no resident name or identifier to indicate which resident they belonged to and the other 10 had Resident #7's name on them. (This State Surveyor attempted to return to record the dates of the forms with missing resident identifying information on 7/10/24 at 5:00 pm but facility staff had already labeled the forms with Resident #7's name after interviews were conducted with the ADON and the DON, so the exact dates of the forms missing information are unknown.) Review of facility form Hemodialysis Communication revealed the form contained a section for date of service, vital signs, pain assessment, vascular access type and site, and any changes with the resident since the last treatment to be communicated to the dialysis center, as well as a section for nurse signature/date/time. The form also contained a section to be completed by the dialysis center nurse regarding medications given during treatment, order changes, follow-ups, and any occurrences during the treatment, as well as a section for nurse signature/date/time. In an interview on 7/10/24 at 4:19 pm, the ADON stated he believed there were currently only two residents in the facility on dialysis, but he needed to check in the computer. The ADON verified in the computer that there were, in fact, only two residents receiving dialysis: Resident #7 on 100 hall and Resident #40 on 300 hall. The State Surveyor requested that the ADON look through 100-200 hall dialysis communication book to see if he could find any issues. He stated that some of the papers did not have a resident name on them. He stated he could tell the forms belonged to Resident #7 because of the medications listed on the form and the shunt site listed but that someone unfamiliar with her would not be able to tell they were hers just by reading the form. The ADON stated that not having a resident name on the communication forms could be a problem. He stated that the communication forms should have been scanned into the resident charts, but he did not know how they would be labeled or if the survey team would have access to them. He stated that without a name on the sheets there was no way to scan the communication form into the correct chart. He stated he had no answer as to why the forms found in the binder had no name. In an interview on 7/10/24 at 4:30 pm, the DON stated that she did not know why the communication sheets in the 100-200 hall dialysis communication book did not have a resident name on them. She stated there was no excuse for that and it was a problem. She also stated the communication sheets should be scanned into the resident chart and she did not know why they were not. Review of facility policy titled Hemodialysis Catheters - Access and Care of, revision date February 2023, revealed, in part: Care Immediately Following Dialysis Treatment: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. The dressing change is done in the dialysis center post-treatment. 2. If the dressing becomes wet, dirty, or not intact, the dressing shall be changed by a licensed nurse trained in this procedure. 3. Mild bleeding from site (post-dialysis) can be expected. Apply pressure to insertion site and contact the dialysis center for instructions. 4. If there is major bleeding from site (post-dialysis), apply pressure to insertion site, and contact emergency services and the dialysis center. Verify that clamps are closed on lumens. This is a medical emergency. Do not leave resident alone until emergency services arrive. The policy did not address documentation of pre/post-dialysis assessments.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 48593

49854

Based on observations, interviews, and record review, the facility failed to establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for three residents (Resident #252, Resident #31, Resident #20) of eight residents observed for infection control in that:

1. Resident #252's catheter drainage collection bag was left on the floor.

2. CNA D and CNA E did not change their gloves after they became contaminated during incontinent care while assisting Resident #20 and did not practice adequate hand hygiene after.

3. CNA F did not change their gloves after they became contaminated during incontinent care while assisting Resident #31

This deficient practice could affect residents with catheters and could result in cross contamination of germs and could result in a urinary tract infection (a painful infection of the urinary system, which includes the kidneys, bladder, urethra, and ureters).

This failure could place residents at risk for cross contamination and the spread of infection.

The findings included:

Review of Resident #252's face sheet dated 07/11/2024, revealed resident was admitted to the facility on [DATE].

Review of Resident #252's History and Physical dated 6/14/2024, revealed diagnoses to include benign prostatic hyperplasia (a condition in which the prostate gland is larger than normal), other retention of urine, chronic kidney disease.

Review of Resident #252's quarterly MDS assessment dated [DATE] revealed Resident had a BIMS (Brief Interview for Mental Status) of 6 suggesting severe cognitive impairment.

Review of Resident #252's care plan dated 06/17/2024 revealed a diagnosis of benign prostatic hyperplasia (a condition in which the prostate gland is larger than normal). It revealed staff was to assess for obstruction (a condition on which the bladder stretches to hold more fluid due to lack of urination), bladder distention, absence of voiding, bladder fullness, and discomfort. It revealed the following orders: change catheter/drainage bag/tubing per doctor ' s orders, Ensure staff aware of correct placement of catheter gravity drainage bag and tubing. Keep tubing/bag below the bladder, do not kink tubing, monitor urine for odor, color, sediments, amount of urine, etc. and report any abnormalities, provide catheter care.

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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 07/11/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 07/09/24 at 10:44 AM, it was observed that the resident ' s Foley bag was hanging from his bed and touching the floor. During an interview on 07/10/24 at 10:53 AM with LVN A He said that the bag should not be touching the floor said there's a risk of contamination of the area if urine was to spill, there would also be a risk of infection to the patient if the bag was touching the floor and there was the potential of germs infecting the resident. LVN A said the bag needed to be always raised from the floor. He said that staff, including him, made rounds throughout the day to ensure these things did not happen but that sometimes it is unavoidable. During an interview on 07/10/24 at 03:02 PM CNA B she stated that the foley bag should not touch the floor because there is a risk of contamination both to the floor and the foley bag if the floors dirty. CNA B said that the potential outcome was that the resident could catch an infection if the bag was contaminated with germs by touching the floor. CNA B said that she has been trained to check on all the residents that have a foley bag every 4 hours and if she observed a foley bag touching the floor, she needed to contact the nurse so that it was changed. During an interview on 07/10/24 at 03:09 PM with DON, it revealed that she had been 3 months in the position as the DON in the facility and that she had worked at the company for about 3 and a half years. DON looked at the picture taken by the state surveyor on 07/09/2024 and after observation of the foley bag being on the floor, DON said that the foley bag should not be touching the floor and that the potential risk was that the patient could get an infection because the foley bag was touching the floor and there was a potential of cross contamination and germs infecting the resident. The DON stated that staff were trained to correct and prevent these issues. The DON said that the residents were checked every 2 hours and as needed. The DON said that CNA's and LVN's were constantly making rounds trying to prevent this kind of situation. Resident #20 Record review of Resident #20's face sheet dated July 11th, 2024, revealed the resident was admitted to the facility on [DATE]. Resident #20 has medical diagnoses that included incomplete paraplegia (impairment in motor or sensory function of the lower extremities), type 2 diabetes, muscle wasting and atrophy (a progressive and degeneration or shrinkage of muscles or nerve tissues), and chronic pain. Review of Resident #20's admission MDS dated [DATE] revealed the resident to be frequently incontinent of urine and bowel. Review of Resident #20's Care Plan dated 06/25/2024 shows a focus of I am at risk for UTIs and skin breakdown R/T incontinent of: Bladder/Bowel D/T Poor cognition with goals of My dignity will be maintained and will not have s/sx of UTI or evidence of skin breakdown through next review date and interventions of Monitor Q 2 hours/PRN for episodes - changes promptly, Provide for appropriate peri-care after each episodes, Perform weekly skin assessment per facility schedule. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations on 07/09/24 at 1005 am of incontinent care for Resident #20 with CNA D and CNA E. Resident had loose stool that had run out of the brief, on his legs and on his back. CNA E wiped the resident's inner thighs, and genital area. CNA E doffed gloves, did not hand sanitize or wash hands, grabbed a new shirt for the resident. CNA E left the room to get a clean brief. The State Surveyor did not witness the staff sanitize or wash hands. After wiping the bowel movement off Resident #20's genital area and bottom, CNA D used a wet wipe to clean the gloves that were visibly soiled with bowel movement. CNA D placed the clean brief with the same gloves. Without changing gloves, CNA D grabbed the residents barrier cream and placed barrier cream on the resident's bottom. The resident was rolled to his back and CNA D placed barrier cream on his genital area. CNA D used a wet wipe to clean the barrier cream off the same gloves. CNA E and CNA D removed the resident's shirt which had bowel movement on it. When the CNAs turned the resident towards CNA D to fix the brief, there was still bowel movement on his back. CNA E wiped resident's bottom. CNA E then removed the soiled draw sheet and latched the clean brief. Without doffing gloves, CNA E moved the wet wipes and covered the resident with a blanket. Both CNAs after doffing their gloves did not wash their hands for a full 30 seconds and did not use a clean paper towel to turn water off. CNA D and CNA E were unavailable for interviews. Resident #31 Record review of Resident #31's face sheet dated July 11th, 2024, revealed the resident was admitted to the facility 05/11/2024. Resident #31 has medical diagnoses that includes urinary tract infection, neuromuscular dysfunction of bladder (a condition where a person lacks bladder control due to brain, spinal cord, or nerve problems.), severe protein calorie malnutrition, muscle wasting and atrophy (a progressive and degeneration or shrinkage of muscles or nerve tissues). Review of Resident #31's 5-day Medicare MDS dated [DATE] revealed the resident to be always incontinent of bowel movements. Resident has a foley catheter. Review of Resident #31's Care Plan dated 06/14/2024 shows a focus of I have potential for impaired skin integrity related to decreased mobility, incontinence, current skin concerns a goal of I will show no evidence of skin breakdown through next review Date. And interventions of Apply barrier cream PRN, Braden Risk assessment per facility protocols, Skin assessment Q week. Observation on 07/09/24 at 11:33 AM of incontinent care for Resident #31 with CNA F and LVN P. Both staff members donned two pairs of gloves (double gloving). After providing foley care and cleaning residents genitals the resident was turned towards LVN P so CNA F could wipe the resident's bottom. The resident began having a bowel movement at this time. CNA F wiped residents bowel movement, removed soiled brief. CNA F removed the outer layer of gloves that were visibly soiled with bowel movement. With the gloves that were under the soiled gloves, CNA F placed a new brief, new draw sheet, and covered the resident with a blanket. CNA F then drained the urine from the resident's foley bag. CNA F, with the same gloves, wiped the residents face with a damp wash rag, brushed the resident's hair, lowered the bed, moved the bedside table to the resident. LVN P used hand sanitizer after leaving room. CNA F did not wash their hands in the room. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 07/11/24 at 10:34 AM with DON and ADON regarding incontinent care. The DON stated that she expected the staff to perform hand hygiene before and after incontinent care and wash their hands if they were visibly soiled. The DON stated the staff were to change gloves and hand sanitize between dirty and clean. The ADON stated the staff were not supposed to double glove during incontinent care to replace changing gloves and sanitizing between dirty and clean. The DON and the ADON stated the staff not changing gloves between dirty and clean, not adequately washing hands, and double gloving can cause a potential cross contamination and goes against infection control. Interview on 07/11/24 at 11:18 AM with LVN P regarding incontinent care. LVN P stated that she always wears double gloves because it was easier and faster than washing hands during incontinent care. LVN P did not think there was anything during care that could have been done better. Interview on 07/11/24 at 11:18 AM with CNA F stated that she always wears multiple pairs of gloves because it [NAME] faster than taking gloves off and sanitizing between glove changes. CNA F did not think this was an issue of cross contamination. POLICY Record review of the facility's policy titled Catheter Care, Urinary dated August 2022 indicated in part: Infection Control; be sure the catheter tubing and drainage bag are kept off the floor. Record review of the facility's policy titled Handwashing/ Hand Hygiene. The policy statement reads This facility considers hand hygiene the primary means to prevent the spread of infections. The policy interpretation and implementation reads in part, 6. Wash hands with soap (antimicrobial or non-antimicrobial) and water for the following situations: when hands are visibly soiled; and after contact with a resident with infectious diarrhea ., and 7.use an alcohol based hand run containing at least 62% alcohol; or, alternatively, soap and water for the following situations: h. before moving from a contaminated body site to a clean body site during resident care; m. after removing gloves; . and 9. The use of gloves does not replace hand washing/ hand hygiene. Intergration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections . under the Procedure - washing hands - portion of the policy states in part 2. rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. and 4. Use towel to turn off the faucet.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 34486 Based on interviews and record review the facility failed to include as part of its QAPI program mandatory training that outlines and informs staff of the elements and goals of the facility's QAPI program for 16 (the Administrator, the DON, the Infection Disease Preventionist, the Social Worker, the Activity Director, the Housekeeping Supervisor, the Maintenance Supervisor, the Director of Food Services, RN H, LVN I, LVN J, LVN K, CNA L, CNA M, CNA N, and CNA O) of 16 employees reviewed for training regarding QAPI. The facility failed to include training regarding the facility's QAPI program in its training for employees. This failure put residents at risk of receiving poor-quality services as a result of staff being unaware of quality control concerns the facility was working to address. Findings included: In interview and record review on 07/11/2024 at 10:40 AM the HR Manager provided a list of employees with the following dates of hire and verbally confirmed the hire dates of these employees: Administrator-9/17/2002, Director of Nurses-11/30/2020, Infection Control Preventionist - 6/3/2024, Social Worker - 3/24/2024, Activity Director - 5/13/2022, Housekeeping Supervisor, 2/18/2019, Maintenance Supervisor-7/10/2023, Director of Food Services - 6/10/2019, RN H - 1/13/22, LVN I-8/18/2023, LVN J - 5/30/23, LVN K-6/14/24, CNA L - 1/12/2023, CNA M - 6/25/2019, CNA N - 4/16/2019, and CNA O - 11/22/23. In interview and record review on 07/11/2024 at 10:40 AM review of the facility orientation and training documents revealed no training regarding the facility's QAPI program to the Administrator, the Director of Nurses, the Infection Control Preventionist, the Social Worker, the Activity Director, the Housekeeping Supervisor, the Maintenance Supervisor, the Director of Food Services, RN H, LVN I, LVN J, LVN K, CNA L, CNA M, CNA N, and CNA O. The HR Manager stated that training regarding the facility's QAPI program was not provided to facility employees. In an interview on 07/11/2024 at 2:15 PM the Administrator-in-training revealed the facility did not provide formal training to employees regarding the QAPI program. The Administrator stated that provision of training about the QAPI program to employees would be beneficial so they could be aware of the quality-related efforts the facility was making. Record review of the facility policy In-service Training, All Staff revised 08/2022 revealed required training topics included elements and goals of the facility QAPI program.