STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676457	A. BUILDING _____ B. WING _____	08/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on,interview and record review the facility failed to ensure that residents received treatment and care in accordance with professional practice and the person-centered care plan for 1 (Resident #2) of 4 residents reviewed for quality of care. A. Resident #2, who had insulin-dependent type 2 diabetes, was a resident in the facility for 6 days before she received insulin leading to a finger stick blood glucose reading of 596. B. Licensed nurses failed to assess Resident #2 for a pressure injury and failed to notify the physician. LVN E failed to obtain a physician order prior to starting treatment of [REDACTED]. The findings included: A. Resident #2 Review of the electronic face sheet on 8/03/20 documented Resident #2 was an [AGE] year-old female admitted on [DATE] and discharged to the hospital on [DATE]. Review of the Nursing Admission Screening/History dated 7/24/20 documented the following for Resident #2: a. Relevant History/DX- member has DM, HTN, dementia, hx of [MEDICAL CONDITION] embolism and right hip fx b. Orientation - to person, place, time and situation c. Communication -difficulty understanding others and difficulty being understood d. Cognition- confused e. Social History/Lifestyle Concerns - Relevant History/Dx - right [MEDICAL CONDITION], DM,[MEDICAL CONDITION]. Skin - bruising right and left antecubital, right hip surgical incision 12 cm long, right and left heels pressure stage 1, moon boots on feet, right hip has wound dressing intact and in place with no noted redness or foul odor g. ADL's/Functional Devices - totally dependent for bed mobility, transfers, walking, locomotion, dressing, toilet use, personal hygiene and bathing. Assistance of staff for eating. h. Other Relevant Dx/Concerns - diabetes, [MEDICAL CONDITION] i. Medications - allupurinol, [MEDICATION NAME], aspirin, [MEDICATION NAME], levetiracetam, [MEDICATION NAME], olmesartan, [MEDICATION NAME] Review of Resident #2's clinical records revealed there was no MDS except for an entry MDS dated [DATE]. 1) Insulin Review of hospital records, Consult Note dated 7/13/20, revealed [DIAGNOSES REDACTED]. Review of hospital records packet sent with Resident #2 on admitted [DATE] to facility had a problem list including Diabetes Mellitus. The medication list did not contain insulin or other diabetic medications. Labs 7/23/20 - 7/24/20 listed glucose levels 88 - 136. Glucose point of care accu-check readings 133 - 194. COVID-19 positive on 7/12/20 but negative on 7/21/20 and 7/23/20. Review of the hospital electronic MAR indicated [REDACTED]. insulin [MEDICATION NAME] (a long-acting insulin) 10 units subq every bedtime. Started 7/13/20. b. insulin [MEDICATION NAME], Humalog (a short-acting insulin) sliding scale subq TID and Q bedtime. Started 7/13/20. Review of the Admission Telephone Report dated 7/24/20, 2:30 PM, revealed Resident #2 had a [MEDICAL CONDITION] due to fall (right hip), DM, HTN. high cholesterol and dementia. Bilateral stage 1 to heels, right surgical (incision) about 12 cm, bilateral bruising to arms upper and lower, bilateral rash to breasts. Report signed by RN H. Review of Weights and Vitals Summary documented Resident #3's Blood Sugars: a. 7/31/20, 8:52 AM- 596 b. 7/30/20, 8:03 AM - 415 c. 7/31/20, 12:19 PM- 450 Review of Resident #2's (Physician's) Order Summary from 7/24/20 through 8/03/20 revealed the following orders: a. 7/30/20 - Accucheck at bedtime for DM b. 7/30/20 - provide sugar-free health shakes 3 times a day for 30 days for poor oral intake c. 7/31/20- Insulin [MEDICATION NAME] Solution pen injector 100 units/ml - Inject as per sliding scale- 70-139 - 0 units 140-180 2 units 181-240 3 u 241-300 4 u 301-350 6 u 351-400 8 u 401-450 10 u, give 10 units and call MD, subcutaneously before meals for DM d. [MEDICATION NAME] tablet 50 mg give 1 tablet by mouth for DM one time a day Review of SW note dated 7/31/20 at 12:24 PM revealed SW met with son and daughter. Daughter stated yesterday when she was talking to (LVN I) noticed he was not aware resident was a diabetic. Insulin has not been administered since admission. Sugar 560. Family requested discharge to hospital. In an telephone interview on 8/03/20 at 8:01 PM, LVN G said she came on shift at 10 PM on 7/24/20. She assisted RN H with the paperwork for Resident #2's admission as the RN had not worked with the electronic computer system in a long time. LVN G said Resident #2 did not come from the hospital with paperwork except for the medication reconciliation. In a telephone interview on 8/04/20 at 2:10 PM, RN H said she remembered getting a small report from the previous nurse and she did not have a report sheet. She said she read through the hospital paperwork. RN H said the hospital medication reconciliation had no orders for insulin. She said there were no diabetic meds. She said she spoke with LVN B, the previous nurse, and he said we will go by the medication reconciliation until the doctor sees her. In telephone interviews on 8/04/20 at 2:31 PM and 8/07/20 at 9:23 AM, LVN B said he did not admit Resident #2 but did take the report from the hospital. LVN B said although report was called around 2 PM, Resident #2 did not arrive until 6:15 PM when he was reporting off. He said he did see a faxed reconciliation that she was on a sliding scale insulin. He said he filled a report sheet and gave it to the oncoming nurse. LVN B said he was handed the resident's electronic hospital records by another nurse and he said in the paperwork he saw the EMAR that said she was on a sliding scale insulin. When he reported off, as the patient was not there yet, he handed the papers to the oncoming nurse and went over the paperwork with her- labs, B/P, meds and pointed out the sliding scale insulin. He said he would have called the doctor to clarify if the resident got insulin or not. In an interview on 8/7/20 at 2:33 PM, LVN I said on 7/30/20, Resident #2's daughter was visiting at the window. He said Resident #2 was not eating well and he showed the daughter how much she had eaten. The daughter said she would go and get some Boost/Ensure without sugar. LVN I said he asked her if the patient was diabetic and she said yes. He said he did not know that. The daughter said she was on insulin and asked him to check her blood sugar. It was 596. He asked the daughter to go and get her insulin. The LVN said he called the doctor and got orders for blood sugars and insulin. In a telephone interview on 8/07/20 at 9:08 AM, the Admissions Coordinator said she gets all of the hospital records and reviews for hi-cost meds, behaviors and equipment, makes sure equipment is in place. She talks to the family and lets them know what the facility offers. All clinicals are given to nursing. She puts everything into a file and emails the file to the team - Nursing, SW, Medical Records Administrator and typically the DON will upload the file, so everyone can see it. She said she includes all paperwork given to her by the hospital. In a telephone interview on 8/04/20 at 5:22 PM, Resident #2's PCP said she saw Resident #2 on Monday (7/27) and she saw nothing on the records about diabetes and saw no diabetic medications. Staff called on 7/30 to let her know the resident's blood sugar and she gave orders for insulin. She also gave orders for labs to be drawn and the resident's A1C was 7.6. (The hemoglobin A1C tests what percentage of your hemoglobin is coated with sugar. The higher the level the poorer the control. A level above 6.5 indicates diabetes- mayoclinic.org) In an interview on 8/05/20 at 10:28 AM, the DON and NFA said hospital records for referrals go to the NFA, DON, BOM, MDS, and Medical Records because she loads it into the profile. The records can't be loaded until the resident actually gets to the facility. During this time Rehab uploaded the records as the clerk in Medical Records was out. The BOM looks at the records for financial, MDS for therapy needs, NFA for all aspects especially expensive meds, DON to see if they can provide the care and medications. Once approved for admission, everything is provided so MD can review. The DON said she did not notice the e-MAR from the hospital. They review the med list for high cost drugs and ask if they are going to be continued. When the patient comes, they come with a final medication list. Review of the facility policy, Admission, Emergency revised September 2012, stated in part that a physician's order for the immediate care and treatment of

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) [REDACTED]. Review of the facility policy Administering Medication, revised December 2012, stated medications shall be administered in a safe and timely manner, and as prescribed. 2) Wounds Review of the Admission Telephone Report dated 7/24/20, 2:30 PM revealed Resident #2 had a [MEDICAL CONDITION] due to fall (right hip), DM, HTN. high cholesterol and dementia. Bilateral stage 1 to heels, right surgical about 12 cm,bilateral bruising to arms upper and lower, bilateral rash to breasts. Report signed by RN H. Review of the Interim Care Plan dated 7/24/20 revealed the resident had impaired skin integrity. The instructions on the Interim Care Plan said to answer each question with information provided by resident, transfer papers, friends and family in admission and readmission to the facility. Once complete, Save/Sign and Lock the tool. Navigate to the CP, click view triggered items now and add the triggers from this assessment to start building the interim care plan. Review of Resident #2's clinical records on 8/05/20 revealed there was no MDS except for the Entry MDS dated [DATE] and there was no care plan. There were no Skin Observation Tools or Wound- Weekly Observation Tools in the record. There was no measurements or description of any wound. Review of Resident #2's (Physician's) Order Summary from 7/24/20 through 8/03/20 revealed the following orders: a. 7/26/20 - Leave [MEDICATION NAME] dressing in place for 1 week. On 8/2/20, resume cleansing right hip per order. May remove and change to [MEDICATION NAME] if soiled one time a day. b. Pressure injury, clean with normal saline, pat dry, apply protective dressing one time a day c. Starting 8/2/20 wound 1: cleanse right hip with normal saline, pat dry, apply 4X4 gauze. d. 7/25/20, wound 2: cleanse left heel with normal saline, pat dry with 4X4 sterile gauze. Apply island dressing every day. Wrap with Kerlix every day. (There were no orders for Resident #2's right heel.) Review of daily Skilled Evaluation from 7/25/20 through 7/31/20 revealed Skin: Skin warm and dry, skin color WNL, mucous membranes moist, turgor normal. Skin intact: NO. Review of the SNF/NF Hospital Transfer Form dated 7/31/20 documented Resident #2 had pain location: sacrum, right [MEDICAL CONDITION]. In a telephone interview on 8/04/20 at 2:10 PM, RN H said she remembered getting a small report from the previous nurse and she did not have a report sheet. RN H said she looked Resident #2 over head to toe. She said the resident did not have any breakdown and she did a thorough skin assessment. In an interview and record review on 8/05/20 at 11:13 AM, Wound Care Nurse LVN F said he was out for 2 weeks and did not see Resident #2 until 7/31/20. She had a right hip surgical incision, bilateral heel wounds and a pressure injury to her sacrum. Before he could assess and get orders, she was transferred out. He said he spoke to her son but only about her upcoming ortho appointment. The heel wounds were unstageable and he believed her sacrum wound started as a DTI. The wound bed was not visible and was unstageable. On a new admission the process was to do an initial skin assessment and to do the Braden if the admitting nurse had not done it. If they have wounds a wound weekly observation tool is completed. He said all nurses have access to the tool. He then contacts the MD for orders and then writes a progress note. He said he will call the RP to keep them informed. A weekly observation tool is also completed on the resident. Wounds are reported to the DON every Thursday at the skin and weight meeting. LVN E showed a new resident's skin assessment where he had completed a Skin Observation Tool that had the location of the wound, type, measurements and staging. He also showed the Wound-Weekly Observation Tool, 1 for each wound, with information, measurements, treatments and equipment used. (Resident #2 did not have any of those assessments). In an interview on 8/05/20 at 12:23 PM, CNA C said she told LVN A that Resident #2's bottom was discolored - like bruised. She did not remember the date. She said the resident would let them turn her. She would be transferred between the bed and the chair using a Hoyer. She was not eating - less than 25% and no more. She would drink the shakes, water and juice. When her diet was changed to pureed she did eat a little better. In an interview on 8/05/20 at 1:06 PM, the DON said there was no facility P&P for skin assessment. It was included in the Wound Care P&P. The initial wound assessment is on the Nursing Admission form. Then within 24 hours the wound care nurse sees. If there is no WCN, the nurses will assess and a Skin Assessment is completed and if there is a wound a daily wound assessment is completed. In an interview on 8/05/20 at 1:15 PM, LVN A said she remembered being told by a CNA that Resident #2 had something on her bottom. She assessed and said she saw something that looked like a skin tear or shearing. She said she did not document it. She said the RNs are the ones that stage. She said she does not remember telling anyone about the wound. She said she did see it was not documented on admission. She said she was told either Monday, Tuesday or Wednesday (7/27, 7/28 or 7/29) as those were the days she worked. She said the skin is assessed on admission and weekly. LVN A said LVN E was helping out with wound care while LVN F was out. In an interview on 8/05/20 at 1:19 PM, the DON said she spoke with LVN E concerning the wound for Resident #2. She said the LVN saw the wound when she was helping with a transfer. She said it looked like a cut but she did not know how to describe it. The DON said that was where the order came from for wound care on 7/30/20. In a telephone interview on 8/05/20 at 4:12 PM, LVN E said she did not look at Resident #2's heels. She was told about the wound on her bottom while the resident was in the shower. She said she created an order for [REDACTED]. She did not call the doctor about it. She said she was told you have to create an order so they know what you are doing. She said she did not document it only created an order. Review of the facility policy Change in a Resident's Condition or Status, revised December 2016, stated in part the nurse will notify the resident's Attending Physician or physician on call when there has been a (an) significant change in the resident's physical/emotional/mental condition or need to alter the resident's medical treatment significantly. A significant change of condition is a major decline or improvement on the resident's status that will not normally resolve itself without intervention by staff or by implementing disease-related clinical interventions (is not self-limiting). The nurse will record on the resident's medical record information relative to changes in the resident's medical/mental condition. Review of the facility policy Wound Care, revised October 2010, did not address skin assessments. It did state the following should be recorded in the resident medical record all assessment date (i.e., wound bed color, size, drainage, etc.) obtained when inspecting the wound. Review of the facility policy Prevention of Pressure Ulcers/Injuries revised July 2017 revealed, in part: Risk Assessment sent: Conduct a comprehensive skin assessment upon admission including skin integrity (any evidence of existing or developing pressure ulcers or injuries). Inspect daily for signs of developing pressure injuries. Inspect pressure points. Monitoring: Evaluate, report and document potential changes in the skin. A request was made to the NFA on 8/10/20 at 11:00 AM for policy and procedures on the use of the Skin Observation Tool and the Wound Weekly Observation Tool. Neither was provided.
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure necessary treatment and services consistent with professional standards of practice to promote healing, prevent infection and prevent new ulcers from developing for 2 (Residents #2 and #3) of 4 residents reviewed for pressure injuries. A. Licensed nurses failed to assess Resident #2 for a pressure injury and failed to notify the physician. LVN E failed to obtain a physician order prior to starting treatment of [REDACTED]. Licensed nurses failed to complete assessments for Resident #3's wounds. This failure placed residents at risk for new or worsening pressure ulcers. The findings included: A. Resident #2 Review of the electronic face sheet on 8/03/20 documented Resident #2 was an [AGE] year-old female admitted on [DATE] and discharged to the hospital on [DATE]. Review of the Nursing Admission Screening/History dated 7/24/20 documented the following for Resident #2: a. Relevant History/DX- member has DM, HTN, dementia, hx of [MEDICAL CONDITION] embolism and right hip fx b. Orientation - to person, place, time and situation c. Communication -difficulty understanding others and difficulty being understood d. Cognition- confused e. Social History/Lifestyle Concerns - Relevant History/Dx - right [MEDICAL CONDITION], DM,[MEDICAL CONDITION]. Skin - bruising right and left antecubital, right hip surgical incision 12 cm long, right and left heels pressure stage 1, (no measurements), moon boots on feet, right hip has wound dressing intact and in place with no noted redness or foul odor g. ADL's/Functional Devices - totally dependent for bed mobility, transfers, walking, locomotion, dressing, toilet use, personal hygiene and bathing. Assistance of staff for eating. h. Other Relevant Dx/Concerns - diabetes, [MEDICAL CONDITION] i. Medications - allupurinol, [MEDICATION NAME], aspirin, [MEDICATION NAME], levetiracetam, [MEDICATION NAME], olmesartan, [MEDICATION NAME] Review of Resident #2's clinical records revealed there was no MDS except for an entry MDS dated [DATE]. Review of the Admission Telephone Report dated 7/24/20, 2:30 PM revealed Resident #2 had a [MEDICAL CONDITION] due to fall (right hip), DM, HTN. high cholesterol and dementia. Bilateral stage 1 to heels, right surgical about 12 cm,bilateral bruising to arms upper and lower, bilateral rash to breasts. Report signed by RN H. Review of the Interim Care Plan dated 7/24/20 revealed the resident had impaired skin integrity. The instructions on the Interim Care Plan said to answer each question with information provided by resident, transfer papers, friends and family in admission and readmission to the facility. Once complete, Save/Sign and Lock the tool. Navigate to the CP, click view triggered items now and add the triggers from this assessment to start building the interim care plan. Review of Resident #2's clinical records on 8/05/20 revealed there was no MDS except for the Entry MDS dated [DATE] and there was no care plan. There were no Skin Observation Tools or Wound- Weekly Observation Tools in the record. There was no measurements or description of any wound. Review of Resident #2's (Physician's) Order Summary from 7/24/20 through 8/03/20 revealed the following orders: a. 7/26/20 - Leave

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F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) [MEDICATION NAME] dressing in place for 1 week. On 8/2/20, resume cleansing right hip per order. May remove and change to [MEDICATION NAME] if soiled one time a day. b. Pressure injury, clean with normal saline, pat dry, apply protective dressing one time a day c. Starting 8/2/20 wound 1: cleanse right hip with normal saline, pat dry, apply 4X4 gauze. d. 7/25/20, wound 2: cleanse left heel with normal saline, pat dry with 4X4 sterile gauze. Apply island dressing every day. Wrap with Kerlix every day. (There were no orders for Resident #2's right heel.) Review of daily Skilled Evaluation from 7/25/20 through 7/31/20 revealed Skin: Skin warm and dry, skin color WNL, mucous membranes moist, turgor normal. Skin intact: NO. Review of the SNF/NF Hospital Transfer Form dated 7/31/20 documented Resident #2 had pain location: sacrum, right [MEDICAL CONDITION]. In a telephone interview on 8/04/20 at 2:10 PM, RN H said she remembered getting a small report from the previous nurse and she did not have a report sheet. RN H said she looked Resident #2 over head to toe. She said the resident did not have any breakdown and she did a thorough skin assessment. In an interview and record review on 8/05/20 at 11:13 AM, Wound Care Nurse LVN F said he was out for 2 weeks and did not see Resident #2 until 7/31/20. She had a right hip surgical incision, bilateral heel wounds and a pressure injury to her sacrum. Before he could assess and get orders, she was transferred out. He said he spoke to her son but only about her upcoming ortho appointment. The heel wounds were unstageable and he believed her sacrum wound started as a DTI. The wound bed was not visible and was unstageable. On a new admission the process was to do an initial skin assessment and to do the Braden if the admitting nurse had not done it. If they have wounds a wound weekly observation tool is completed. He said all nurses have access to the tool. He then contacts the MD for orders and then writes a progress note. He said he will call the RP to keep them informed. A weekly observation tool is also completed on the resident. Wounds are reported to the DON every Thursday at the skin and weight meeting. LVN E showed a new resident's skin assessment where he had completed a Skin Observation Tool that had the location of the wound, type, measurements and staging. He also showed the Wound-Weekly Observation Tool, 1 for each wound, with information, measurements, treatments and equipment used. (Resident #2 did not have any of those assessments). In an interview on 8/05/20 at 12:23 PM, CNA C said she told LVN A that Resident #2's bottom was discolored - like bruised. She did not remember the date. She said the resident would let them turn her. She would be transferred between the bed and the chair using a Hoyer. She was not eating - less than 25% and no more. She would drink the shakes, water and juice. When her diet was changed to pureed she did eat a little better. In an interview on 8/05/20 at 1:06 PM, the DON said there was no facility P&P for skin assessment. It was included in the Wound Care P&P. The initial wound assessment is on the Nursing Admission form. Then within 24 hours the wound care nurse sees. If there is no WCN, the nurses will assess and a Skin Assessment is completed and if there is a wound a daily wound assessment is completed. In an interview on 8/05/20 at 1:15 PM, LVN A said she remembered being told by a CNA that Resident #2 had something on her bottom. She assessed and said she saw something that looked like a skin tear or shearing. She said she did not document it. She said the RNs are the ones that stage. She said she does not remember telling anyone about the wound. She said she did see it was not documented on admission. She said she was told either Monday, Tuesday or Wednesday (7/27, 7/28 or 7/29) as those were the days she worked. She said the skin is assessed on admission and weekly. LVN A said LVN E was helping out with wound care while LVN F was out. In an interview on 8/05/20 at 1:19 PM, the DON said she spoke with LVN E concerning the wound for Resident #2. She said the LVN saw the wound when she was helping with a transfer. She said it looked like a cut but she did not know how to describe it. The DON said that was where the order came from for wound care on 7/30/20. In a telephone interview on 8/05/20 at 4:12 PM, LVN E said she did not look at Resident #2's heels. She was told about the wound on her bottom while the resident was in the shower. She said she created an order for [REDACTED]. She did not call the doctor about it. She said she was told you have to create an order so they know what you are doing. She said she did not document it only created an order. B. Resident #3 Review of the face sheet dated 8/10/20 documented Resident #3 was a [AGE] year old male admitted on [DATE]. Review of the History and Physical dated 8/6/20 revealed Resident #3 had [DIAGNOSES REDACTED]. Review of the Resident #3's clinical records revealed no MDS except for an entry MDS dated [DATE]. Review of Resident #3's Interim Care Plan dated 7/25/20 revealed he had impaired skin integrity on admission. The instructions on the Interim Care Plan said to answer each question with information provided by resident, transfer papers, friends and family in admission and readmission to the facility. Once complete, Save/Sign and Lock the tool. Navigate to the CP, click view triggered items now and add the triggers from this assessment to start building the interim care plan. Review of Resident #4's care plan dated 7/26/20, only had 1 problem listed - risk for psychological well-being. Review of Resident #3's MAR indicated [REDACTED]. Review of the Nursing Admission assessment dated [DATE] revealed Resident #3 had right toe necrosis and pressure ulcer to sacrum. Review of the Nurse's Note dated 7/25/20 revealed Resident #3 had multiple wounds, arterial on right heel and unstageable to sacrum. Review of the Skin Observation Tool dated 7/27/20 revealed an open area to Resident #3's coccyx, dressing in place. There was no wound measurements or description of the wound. There was no Wound-Weekly Observation Tool until 8/7/20. In an interview on 8/07/20 at 2:24 PM, LVN F said Resident #3 has a pressure ulcer on his sacrum. It has slough adhered to the wound. LVN F said he has 24 hours to see a new admission and fill out the Skin Observation tool and the Weekly Wound Observation Tool if the resident has a wound. LVN F said when he was out, someone was covering and that person should have done the assessments. He said there are no standing orders for wounds. The physician needs to be notified to get orders for treatment. Review of the facility policy Change in a Resident's Condition or Status, revised December 2016, stated in part the nurse will notify the resident's Attending Physician or physician on call when there has been a (an) significant change in the resident's physical/emotional/mental condition or need to alter the resident's medical treatment significantly. A significant change of condition is a major decline or improvement on the resident's status that will not normally resolve itself without intervention by staff or by implementing disease-related clinical interventions (is not self-limiting). The nurse will record on the resident's medical record information relative to changes in the resident's medical/mental condition. Review of the facility policy Wound Care, revised October 2010, did not address skin assessments. It did state the following should be recorded in the resident medical record all assessment date (i.e., wound bed color, size, drainage, etc.) obtained when inspecting the wound. Review of the facility policy Prevention of Pressure Ulcers/Injuries revised July 2017 revealed, in part: Risk Assessment sent: Conduct a comprehensive skin assessment upon admission including skin integrity (any evidence of existing or developing pressure ulcers or injuries). Inspect daily for signs of developing pressure injuries. Inspect pressure points. Monitoring: Evaluate, report and document potential changes in the skin. A request was made to the NFA on 8/10/20 at 11:00 AM for policy and procedures on the use of the Skin Observation Tool and the Wound Weekly Observation Tool. Neither was provided.
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide pharmaceutical services to meet the needs of 1 (Resident #2) of 4 residents reviewed for pharmacy services. Resident #2, who had insulin-dependent type 2 diabetes, was a resident in the facility for 6 days before she received insulin leading to a finger stick blood glucose reading of 596. This failure placed residents at risk for serious illness and/or injury from not receiving medications. The findings included: Review of the electronic face sheet on 8/03/20 documented Resident #2 was an [AGE] year-old female admitted on [DATE] and discharged to the hospital on [DATE]. Review of the Nursing Admission Screening/History dated 7/24/20 documented the following for Resident #2: a. Relevant History/DX- member has DM, HTN, dementia, hx of [MEDICAL CONDITION] embolism and right hip fx b. Orientation - to person, place, time and situation c. Communication -difficulty understanding others and difficulty being understood d. Cognition- confused e. Social History/Lifestyle Concerns - Relevant History/Dx - right [MEDICAL CONDITION], DM,[MEDICAL CONDITION]. Skin - bruising right and left antecubital, right hip surgical incision 12 cm long, right and left heels pressure stage 1, moon boots on feet, right hip has wound dressing intact and in place with no noted redness or foul odor g. ADL's/Functional Devices - totally dependent for bed mobility, transfers, walking, locomotion, dressing, toilet use, personal hygiene and bathing. Assistance of staff for eating. h. Other Relevant Dx/Concerns - diabetes, [MEDICAL CONDITION] i. Medications - allupurinol, [MEDICATION NAME], aspirin, [MEDICATION NAME], levetiracetam, [MEDICATION NAME], olmesartan, [MEDICATION NAME] Review of Resident #2's clinical records revealed there was no MDS except for an entry MDS dated [DATE]. 1) Insulin Review of hospital records, Consult Note dated 7/13/20, revealed [DIAGNOSES REDACTED]. Review of hospital records packet sent with Resident #2 on admitted [DATE] to facility had a problem list including Diabetes Mellitus. The medication list did not contain insulin or other diabetic medications. Labs 7/23/20 - 7/24/20 listed glucose levels 88 - 136. Glucose point of care accu-check readings 133 - 194. COVID-19 positive on 7/12/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676457	A. BUILDING _____ B. WING _____	08/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) but negative on 7/21/20 and 7/23/20. Review of the hospital electronic MAR indicated [REDACTED]. insulin [MEDICATION NAME] (a long-acting insulin) 10 units subq every bedtime. Started 7/13/20. b. insulin [MEDICATION NAME], Humalog (a short-acting insulin) sliding scale subq TID and Q bedtime. Started 7/13/20. Review of the Admission Telephone Report dated 7/24/20, 2:30 PM, revealed Resident #2 had a [MEDICAL CONDITION] due to fall (right hip), DM, HTN. high cholesterol and dementia. Bilateral stage 1 to heels, right surgical (incision) about 12 cm, bilateral bruising to arms upper and lower, bilateral rash to breasts. Report signed by RN H. Review of Weights and Vitals Summary documented Resident #3's Blood Sugars: a. 7/31/20, 8:52 AM- 596 b. 7/30/20, 8:03 AM - 415 c. 7/31/20, 12:19 PM- 450 Review of Resident #2's (Physician's) Order Summary from 7/24/20 through 8/03/20 revealed the following orders: a. 7/30/20 - Accucheck at bedtime for DM b. 7/30/20 - provide sugar-free health shakes 3 times a day for 30 days for poor oral intake c. 7/31/20- Insulin [MEDICATION NAME] Solution pen injector 100 units/ml - Inject as per sliding scale- 70-139 - 0 units 140-180 2 units 181-240 3 u 241-300 4 u 301-350 6 u 351-400 8 u 401-450 10 u, give 10 units and call MD, subcutaneously before meals for DM d. [MEDICATION NAME] tablet 50 mg give 1 tablet by mouth for DM one time a day Review of SW note dated 7/31/20 at 12:24 PM revealed SW met with son and daughter. Daughter stated yesterday when she was talking to (LVN I) noticed he was not aware resident was a diabetic. Insulin has not been administered since admission. Sugar 560. Family requested discharge to hospital. In an telephone interview on 8/03/20 at 8:01 PM, LVN G said she came on shift at 10 PM on 7/24/20. She assisted RN H with the paperwork for Resident #2's admission as the RN had not worked with the electronic computer system in a long time. LVN G said Resident #2 did not come from the hospital with paperwork except for the medication reconciliation. In a telephone interview on 8/04/20 at 2:10 PM, RN H said she remembered getting a small report from the previous nurse and she did not have a report sheet. She said she read through the hospital paperwork. RN H said the hospital medication reconciliation had no orders for insulin. She said there were no diabetic meds. She said she spoke with LVN B, the previous nurse, and he said we will go by the medication reconciliation until the doctor sees her. In telephone interviews on 8/04/20 at 2:31 PM and 8/07/20 at 9:23 AM, LVN B said he did not admit Resident #2 but did take the report from the hospital. LVN B said although report was called around 2 PM, Resident #2 did not arrive until 6:15 PM when he was reporting off. He said he did see a faxed reconciliation that she was on a sliding scale insulin. He said he filled a report sheet and gave it to the oncoming nurse. LVN B said he was handed the resident's electronic hospital records by another nurse and he said in the paperwork he saw the EMAR that said she was on a sliding scale insulin. When he reported off, as the patient was not there yet, he handed the papers to the oncoming nurse and went over the paperwork with her- labs, B/P, meds and pointed out the sliding scale insulin. He said he would have called the doctor to clarify if the resident got insulin or not. In an interview on 8/7/20 at 2:33 PM, LVN I said on 7/30/20, Resident #2's daughter was visiting at the window. He said Resident #2 was not eating well and he showed the daughter how much she had eaten. The daughter said she would go and get some Boost/Ensure without sugar. LVN I said he asked her if the patient was diabetic and she said yes. He said he did not know that. The daughter said she was on insulin and asked him to check her blood sugar. It was 596. He asked the daughter to go and get her insulin. The LVN said he called the doctor and got orders for blood sugars and insulin. In a telephone interview on 8/07/20 at 9:08 AM, the Admissions Coordinator said she gets all of the hospital records and reviews for hi-cost meds, behaviors and equipment, makes sure equipment is in place. She talks to the family and lets them know what the facility offers. All clinicals are given to nursing. She puts everything into a file and emails the file to the team - Nursing, SW, Medical Records Administrator and typically the DON will upload the file, so everyone can see it. She said she includes all paperwork given to her by the hospital. In a telephone interview on 8/04/20 at 5:22 PM, Resident #2's PCP said she saw Resident #2 on Monday (7/27) and she saw nothing on the records about diabetes and saw no diabetic medications. Staff called on 7/30 to let her know the resident's blood sugar and she gave orders for insulin. She also gave orders for labs to be drawn and the resident's A1C was 7.6. (The hemoglobin A1C tests what percentage of your hemoglobin is coated with sugar. The higher the level the poorer the control. A level above 6.5 indicates diabetes- mayoclinic.org) In an interview on 8/05/20 at 10:28 AM, the DON and NFA said hospital records for referrals go to the NFA, DON, BOM, MDS, and Medical Records because she loads it into the profile. The records can't be loaded until the resident actually gets to the facility. During this time Rehab uploaded the records as the clerk in Medical Records was out. The BOM looks at the records for financial, MDS for therapy needs, NFA for all aspects especially expensive meds, DON to see if they can provide the care and medications. Once approved for admission, everything is provided so MD can review. The DON said she did not notice the e-MAR from the hospital. They review the med list for high cost drugs and ask if they are going to be continued. When the patient comes, they come with a final medication list. Review of the facility policy, Admission, Emergency revised September 2012, stated in part that a physician's order for the immediate care and treatment of [REDACTED]. Review of the facility policy Administering Medication, revised December 2012, stated medications shall be administered in a safe and timely manner, and as prescribed.