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 _____	07/17/2020

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 0732 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Post nurse staffing information every day.** Based on observation, interview and record review the facility failed to post the nurse staffing data on a daily basis at the beginning of each shift. This failure could place residents at risk for having staffing information easily accessible to them. The findings included: Observation on 7/17/20 at 9:23 AM, revealed staffing information was not posted. In an observation and interview on 7/17/20 at 11:04 AM, the DON showed where the posted staffing information was supposed to be (outside of the DON office door) and it was not there. She said she did not have it ready yet. Review of the facility policy Posting Direct Care Daily Staffing Numbers, revised July 2016, stated the facility will post, on a daily basis for each shift, the number of nursing personnel responsible for providing care to residents. Within 2 hours of the beginning of each shift, the number of Licensed Nurses (RNs, LPNs and LVNs) and the number of unlicensed nursing personnel (CNAs) directly responsible for resident care will be posted in a prominent location (accessible to residents and visitors) and in a clear and readable format.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** Based on observation, interview and record review the facility failed to establish and maintain an infection control and prevention program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as evidenced by: A. Laundry barrels were overflowing with COVID-19 infected laundry inside and outside of the laundry. B. Laundry bags with soiled linen were on the floor of the laundry. C. The facility did not notify the State Agency of 22 COVID-19 positive residents and 19 COVID-19 positive staff. D. LVN A did not date an opened container of Med Pass 2.0 when opened and it was not on ice/refrigerated. E. CNA C, who was COVID-19 positive, was working in the facility on the COVID-19 unit which was not in accordance with facility policy. This failure could place residents and staff at risk of exposure to food-borne diseases and to COVID-19 causing illness or death. The findings included: A. CNA Review of the facility personnel list with highlighted staff that were positive for COVID-19, CNA C was on the list for positive COVID-19. The list was provided by the DON on 7/03/20. In an interview on 7/03/20 at 2:19 PM, the DON said there were 12 positive COVID-19 residents and 14 staff that have tested positive. The Health Department was notified 7/3/20. The DON said staff who were positive were working the COVID hall only. The DON said that CNA C had worked that day and the day before. First, the DON said CNA C entered through the back door then said she entered through the front door wearing an N95 mask and either goggles or face shield. The DON said they don at the front of the hallway and doff at the exit. She said CNA C was not allowed in the breakroom on that hallway and had to leave the building for lunch. In an interview on 7/17/20 at 12:24 PM, NFA said he had no copies of CNA C's positive report or release from the Health Department. She tested positive on 6/24/20 and was allowed to work because she was positive and worked the positive hall. She was not allowed to stay in building for breaks. She had to wear PPE for check in at front of building and then go to unit for gowning. There was no staff to send to help and they were short. The NFA said he made the decision for her to work. Review of the facility COVID-19 Addendum Policy and Procedures, dated 3/12/20, stated in part: Asymptomatic employees may continue to work pending test results with proper PPE usage, and approval from the Director of Nursing. Any staff member who tests positive for COVID-19 must inform facility management, and do not enter the facility until they are no longer symptomatic and have 2 negative test results within 2 days of each other. B. Reporting In an interview on 7/03/20 at 2:19 PM, the DON said there were 12 positive COVID-19 residents and 14 staff that have tested positive. The Health Department was notified 7/3/20. The NFA said he forget to notify HHSC. The DON said she had told the HHSC Program Manager but they had not called in an intake. She said they still had time and would do so. Review of the State Intake Log for the facility on 7/03/20 revealed no self-report for positive COVID-19 residents/staff. Review on 7/16/20 of the State Intake Log for this facility revealed no self-report for positive COVID residents/staff. Review of the facility COVID-19 Addendum Policy and Procedures, dated 3/12/20, addressed reporting to the local Health Department but did not address reporting to the State Agency. Review of a communication to long term care providers dated 4/1/20 stated in part that effective immediately, a provider must report every presumptive and confirmed case of COVID-19 in staff and individuals receiving services from the provider as a self-reported incident. A presumptive or confirmed case is considered a critical incident. Providers (other than HCS and TxHmL providers) must notify HHSC through TULIP (link is external) or by calling Complaint and Incident Intake (CII). B. Laundry Observation on 7/17/20 at 8:57 AM, revealed the following: a. The laundry is in a building attached to the facility but does not have an entrance into the facility. Outside of the laundry entrance door were 2 laundry barrels overflowing with yellow (infectious) laundry bags and 1 clear bag. There was another barrel with a yellow laundry bag overflowing with lid sitting on top and 2 other barrels with lids not securely closed. b. Inside the laundry room in the soiled linen (washer) area were 2 laundry bags (1 large clear bag and 1 small clear bag) laying on the floor and a laundry cart overflowing with yellow laundry bags and uncovered. There was another yellow laundry bag laying on the floor. c. There were 4 large bags of clothing on the floor of the dryer room. In an interview on 7/17/200 at 8:57 AM, Laundry Aide D said the laundry bags were supposed to be inside the laundry barrels and the lid closed. She said the CNAs bring the barrels like that and throw the bags on top. Laundry Aide D said she had been the facility for 3 weeks and said there were not enough barrels to put all of the soiled laundry in. She said the yellow bags were infected laundry. She washes the laundry in whatever washer is available, but she does not mix a load with infectious and non-infectious linen. She said so much laundry comes in she cannot keep it inside of the carts that she has. Laundry Aide D said the 4 large bags of clothing on the floor of the dryer room belonged to residents that had gone to the hospital. In an interview on 7/17/20 at 11:04 AM, the DON said the CNAs have been educated on infection control and the handling of linens. The DON said the linen bags go into barrels and the barrels have to close. They should not be stacking linen on top of the barrels. Review of a facility in-service on 6/26/20, provided in response to request for a facility policy on laundry transportation and storage, included a W.H.O. guidance which stated in part to contain the used equipment or soiled linen and waste in a manner that prevents the containers of bags from opening or bursting during transport. C. Med Cart Observation on 7/17/20 at 9:23 AM revealed the 100 hall medication cart had an opened, and undated, container of Med Pass 2.0. It was not on ice and warm to the touch. The label on the Med Pass 2.0 said it can remain out for 4 hours after opening otherwise it needs to be refrigerated. In an interview on 7/17/20 at 9:25 AM, LVN A said the Med Pass has to be on ice but there was no ice today. He said he opened it yesterday. The LVN preceded to date the carton with the date of 7/15/20. In an interview on 7/17/20 at 11:04 AM, the DON said the Med Pass 2.0 was to be dated when opened/poured. Review of the manufacturer's web site https://www.hormelhealthlabs.com/resources/for-healthcare-professionals/product-protocols/med-pass-fortified-nutritional-shake-medication-pass-program/ on 7/29/20 revealed that MED PASS 2.0/MED PASS 2.0 Reduced Sugar needs to be kept at refrigerated temperature (34-40 degrees F) once opened. If kept at this temperature range, product is good for 4 days from the time opened. If product is opened and not refrigerated, product should be discarded after 4 hours.

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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