STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265756	A. Building B. Wing	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethesda Southgate	5943 Telegraph Road Saint Louis, MO 63129

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25232 Based on observation, interviews, record review, and policy review, the facility failed to ensure residents who self-administered medications had a self-administration of medications assessment, a physician's order, and a care plan completed for one of one resident (Resident (R) 134) reviewed for self-administration of medications out of a sample of 23 residents. Failure to assess and care plan residents for self-administration of medications increases the potential of medication errors for residents. Findings include: During medication pass observation with Licensed Practical Nurse (LPN) 1 on 07/07/24 at 11:56 AM, she placed one tablet of ferrous sulfate 325 milligrams (mg) into a clear medication cup. LPN1 stated that was all R134 received at this time. LPN1 then entered R134's bedroom, where R134 was sitting up in her wheelchair with the overbed table in front of her. LPN1 placed the medication cup on the table and told R134 that the medication was her iron pill. Then LPN1 walked out of the room. The observing surveyor stayed in R134's bedroom until R134 took the medication, which was two to three minutes later. Review of R134's "Face Sheet" (facility provided) revealed R134 was admitted to the facility on [DATE] with a diagnosis including anemia. Review of admission "Minimum Data Set (MDS)" with Assessment Reference Date (ARD) of 06/30/24 revealed a "Brief Interview for Mental Status (BIMS)" 15 out of 15, indicating R134 was cognitively intact. Review of R134's electronic medical record (EMR), located under tab "Evaluations/Forms" revealed no evidence of a self-medication administration form. Review of R134's "Orders" (facility provided) revealed "Ferrous sulfate 325 mg, oral, three times a day [TID], starting 06/24/24." There was no indication R134 was to self-administrator the medication. Review of R134's "Resident Profile Report" (facility provided) revealed no evidence of a care plan for self-administration of medication. (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: 265756	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2024
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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/09/24 at 11:00 AM, the Director of Nursing (DON) confirmed R134 has not been assessed for self-administering medications and stated that nurses were not to leave medication with residents without watching them take the medication. During an interview on 7/10/24 at 10:00 AM, LPN1 confirmed that medication should not be left with residents. LPN1 stated she usually did not leave medication with a resident. LPN1 confirmed she should not have left the room until R134 took the medication. Review of facility policy titled "2.1 Self Administering Medications," revised 08/2018, revealed "To provide general guidelines to nursing staff regarding resident self-administration of medications . Policy: Medications may be self-administered only after the resident has been evaluated by an interdisciplinary team to determine that the resident can safely self-administer medications and with administrator/Executive Director approval. An evaluation will be completed and documented prior to allowing self-administration of medications, quarterly, with any change of condition or for any route not previously evaluated to be given (example: evaluated to self-administer oral medications only and later has inhaler ordered) . If the evaluation indicates the resident may self-administer medications, the resident's/community member's physician must also give an order allowing the self-administration . Practice: . 3. All medication will be kept in a locked container at the bedside/apartment. The resident/community member, the charge nurse/Certified Medication Tech (CMT) and the Director of Nursing (DON) will each have a key. 4. Self-administration will be addressed in the resident's/community member's care plan/individual service plan."

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36898 Based on record review, interview, and facility policy review, the facility failed to ensure one of three residents and their representatives (Resident (R) 1) reviewed for facility initiated emergent hospital transfers were provided with written transfer notice that contained all required information. This failure has the potential to affect the resident and/or the Resident Representatives (RR) by not having the knowledge of where and why a resident was transferred, and/or how to appeal the transfer, if desired. Findings include: Review of R1's untitled and undated face sheet provided by the facility revealed the resident was most recently readmitted to the facility on [DATE] with diagnoses which included intracranial hemorrhage, persistent vegetative state, and spastic hemiplegia. Review of R1's SNF-SBAR [Skilled Nursing Facility - Situation, Background, assessment, and Recommendation] document, dated 06/17/24 and provided by the facility, revealed . NP [nurse practitioner] came in and this nurse had reported to NP that resident O2 sats [oxygen saturations] lower 90s, upper 80s. Course lung sounds all lobes with audible whz [wheezing]. N.O. [new order] received to send pt [patient] to ER [emergency room]. During an interview on 07/10/24 at 3:55 PM, the Administrator confirmed no written notification was sent to the resident's court appointed guardian for the transfer on 06/17/24. The Administrator stated it was her expectation the facility would follow their policy related to resident transfers and written information being provided. Review of the facility's policy titled, Discharge/Transfer of a Resident, Including Against Medical Advice, revised 12/2022 revealed Purpose: To provide guidelines when discharging or transferring a resident to another health care residence . Exceptions to the 30-day requirement apply when the transfer or discharge is affected because: . An immediate transfer or discharge is required by the resident's urgent medical need . Contents of the transfer/discharge notice must include: The reason for the transfer, The effective date of the transfer or discharge, An explanation of the right to appeal the transfer or discharge to the State .Provide transfer/discharge notice to the resident/representative . as indicated .

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F 0686

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Note: The nursing home is disputing this citation.

Provide appropriate pressure ulcer care and prevent new ulcers from developing.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 36898

Based on observation, interview, record review, and review of the facility's policy, the facility failed to ensure residents' pressure ulcers were assessed and received the necessary treatment and services to promote healing and to prevent worsening of pressure ulcers for one of three residents (Resident (R) 1) reviewed for pressure out of 23 sampled residents. R1 had a history of a pressure ulcer on her left pinky finger healing and reopening. The facility failed to ensure measures were taken to prevent the pressure ulcer from reopening and worsening from a stage 2 pressure ulcer to a stage 3 pressure ulcer. Additionally, the facility started treatment on the pressure ulcer without notifying and obtaining a physician's order. These failures placed R1 at risk for further worsening of the pressure ulcer.

Findings include:

Review of R1's untitled and undated face sheet provided by the facility revealed the resident was most recently readmitted to the facility on [DATE] with diagnoses which included intracranial hemorrhage (bleeding in the skull), persistent vegetative state, and spastic hemiplegia (type of paralysis where muscles contract uncontrollably).

Review of R1's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/26/24, located in Aspen MDS Viewer, revealed the resident was originally admitted to the facility on [DATE]. Continued review of the MDS revealed the facility assessed the resident to be severely impaired for cognitive skills for daily decision making. The MDS indicated the facility assessed the resident had limitations in her range of motion (ROM) as she had upper and lower extremity impairment to both sides. The facility assessed R1 to be at risk for developing pressure, had no unhealed pressure ulcers, and had moisture associated skin damage (MASD).

Review of R1's care plan titled, Resident Profile Report, reviewed on 11/13/20 and provided by the facility, revealed for the area of Skin . I currently have a stage 2 [pressure] to my left pinky finger. OT [occupational therapy] is going to see me to see if there is a hand splint that would work for me. My goal is for this area to heal and remain free from skin breakdown .

Review of R1's care plan titled, Resident Profile Report, reviewed on 11/20/20 and provided by the facility, revealed for the area of Skin.I currently have an open area to my left pinky finger. My nurse is applying a tx [treatment] to this area. OT has seen me and ordered a soft hand splint that would work for me. My goal is for this area to heal and remain free from skin breakdown .

Review of R1's Visit Report for [R1's Name], dated 11/17/20, completed by the facility's contracted wound care physician and provided by the facility revealed . Chief Complaint . Left small finger pressure ulcer . LSP [left small pinky] pressure ulcer where finger is pressed against the adjacent ring finger noted 11/08 [11/08/20]. Duoderm gel [pressure treatment medication] started with dry dressing-has resolved on exam today to fragile epithelium. Noted as a stage 2 pu [pressure ulcer]. Has attempted to use towel rolls to limit contractures of the hand/fingers but she will not hold on to these. OT consulted .

(continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of R1's Visit Report for [R1's Name], dated 02/11/21, completed by the facility's contracted wound care physician and provided by the facility revealed . Chief Complaint . Recurrent Left small finger[LSF] pressure ulcer . LSF pressure ulcer where finger is pressed against the adjacent ring finger noted 11/08/ [11/08/20]. Had resolved after 2nd reccurence [sic] but reopened and worse this time. Appears maybe the thumb is reaching across and irritating this part of the finger. Has attempted splinting, dressings before and most have not stayed on well. This recurrence first noted 02/04 [02/04/21] . Review of R1's Visit Report for [R1's Name], dated 03/16/21, completed by the facility's contracted wound care physician and provided by the facility revealed . Chief Complaint . Recurrent Left small finger pressure ulcer, wound L [left] thumb . Currently dressing order is foam. CMC [carpometacarpal] thumb brace caused a wound at the edge on the thumb, maybe from patient attempting to get the splint off-has been padded with moleskin. This wound is smaller, but now open, partial thickness-dressed with gauze today . Review of R1's care plan titled, Resident Profile Report, reviewed on 07/02/24 and provided by the facility, revealed for the area of Restorative Therapy . I will not wear hand rolls, so they have been discontinued-please do ROM to my hands as I allow . The care plan also revealed for the area of Skin, I am at risk for impaired skin integrity due to immobility, incontinence, involuntary movements, and comorbidities that put my skin at risk for breakdown. Please check my skin daily with care and inform the nurse of any skin issues . There was not documented evidence of when the hand rolls were started, worn, or refused. Review of R1's Wound Assessment Report, dated 07/10/24, provided by the facility and completed by the facility's contracted wound care revealed .Wound 1: Key Facts .Pressure Injury-Stage III [stage 3] .Onset date 07/10/24. Location .Hand, Left 5th digit [left pinky finger] .Status .Healed .Facility acquired-Yes. Wound 1: Assessment. Wound edge: attached. Peri-wound: Erythema, Fragile .Drainage: Minimum: Clear, thins, watery (serous) .Stage III [stage 3] .Wound 1: Images & Measurements. L x W x D [length by width by dept] 0.6 x 0.4 x 0.1 cm [centimeters] .Area 0.2 cm. Volume 0.0 cm. Color R [red]: 88%, Y [yellow] 11%, B [black]: 1% . Review of R1's physician Order Sheet, dated 07/10/24 and provided by the facility revealed Wound Care TAR [treatment administration record] . Pressure ulcer, Little finger, Left, Other, BID [twice daily], Cleanse left little finger (5th digit) with wound cleanser. Apply zinc to 5th finger twice daily and PRN [as needed]. The order did not indicate if any dressing was to be applied. Review of R1's skin assessment documentation titled, Flowsheet Print Request, dated 05/29/24 through 06/21/24 and provided by the facility revealed on 06/21/24 (date the resident was readmitted to the facility from the hospital) revealed . Skin Abnormalities General . none . Review of R1's skin assessment documentation titled, Flowsheet Print Request, dated 06/28/24 through 07/10/24 and provided by the facility revealed on 06/28/24 . Skin Integrity General-intact . On 07/05/24, it was documented . Skin Integrity General- Localized abnormality . Skin Abnormalities General Comment-chafing palm of L [left] hand, erythema to buttock . There was no documented evidence of any skin abnormalities to the resident's left pinky finger. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of R1's would treatment documentation titled, Flowsheet Print Request, dated 06/21/24 through 07/10/24 revealed no documented evidence of any treatments order and/or completed to R1's left pinky finger. Review of R1's active physician Orders, provided by the facility revealed a wound care order dated 06/21/24 of Wound Care TAR . erythema, Abdomen, Dry, BID Cleanse area around gtube with wound cleanser and pat dry. Apply calvida [used for wound treatment] and use t-drain sponge underneath g-tube. There was no documented evidence of any ordered treatments to R1's left pinky finger. Observation and interview on 07/09/24 at 9:33 AM of R1 revealed she was lying in her bed, eyes open and just finished receiving a bolus tube feeding from Licensed Practical Nurse (LPN) 2. The resident had a dressing to her left hand. When asked about the dressing to R1's left hand, LPN2 stated the dressing was due to the resident's left hand being contracted and her nail digging into her skin causing a wound. There was no preventive device in place to the resident's left hand. Observation on 07/09/24 at 11:25 AM revealed R1 lying in bed, eyes closed, with a dressing to her left hand, with no device in place in her left hand. During an interview on 07/10/24 at 11:55 AM, when asked about the dressing that was applied to R1's left hand, the Director of Nursing (DON) stated the dressing to her left hand was typically applied for the resident's pressure injury. The DON stated the resident reopened it when she rubbed her finger against her thumb. When the DON was asked if she could provide any documented evidence where the facility had attempted interventions to prevent the pressure for reoccurring and/or worsening, the DON stated she would look for nursing documentation to show the resident was not compliant with the interventions attempted. The DON stated the facility had attempted everything they could think of to prevent the reopening of the pressure to the left pinky finger. When asked what interventions had been attempted, the DON stated they have tried hand rolls such as wash clothes, clear plastic device that sits in the palm (palm protector), and event tried covering the area with dressings; however, the resident would dig until she removed the covering. During an interview on 07/10/24 at 1:35 PM, the DON stated she was unsure whether the pressure sore was on R1's left hand or her right hand. The DON stated they (facility) were still looking for documentation over the last few years of attempted and failed interventions to prevent the reopening and worsening of the pressure. During a subsequent interview on 07/10/24 at 2:07 PM, the DON provided some documentation related to R1's noncompliance with preventative devices. The DON was again asked what the facility has done to prevent the worsening of R1's pressure ulcer on her left pinky finger from reopening and worsening. The DON stated the facility had attempted the use of a palm protector at one time (could not recall the timeframe); however, she did not know how long this was used or attempted to be used. The DON stated, whatever is in the [physician] orders, When asked if she could provide documented evidence where devices such as the palm protector were ordered and then discontinued, the DON stated, I don't know. I'll have to check the chart. The DON stated R1 was ordered the palm protector on 11/27/20 to her left hand at all times; however, there was no documented evidence the palm protector was being applied, no documented evidence of the resident's noncompliance, no TAR, and no documented evidence when the order was discontinued. When asked if there was any type of documented evidence such as at TAR or Certified Nursing Assistant (CNA) documentation of the attempted devices and of R1's noncompliance, the DON stated not every order for devices goes on a TAR. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an observation with LPN2 on 07/10/24 at 2:30 PM, R1 was lying on her back with her head turned to the left, facing the wall behind her bed. R1's left hand was first observed under the flat sheet on her bed. The nurse lifted her hand from under the sheet, observed what appeared to be a blister that had popped on the palm side of her 5th finger (left pinky finger) and observed her thumb hitting this area. There was slight redness noted on her finger and around the popped blister area, which was an irregular circle shaped with no drainage, and clean edges. There was no dressing on the finger. LPN2 stated R1 has had the open area since she returned to the facility from her most recent hospital stay. When asked by the surveyor how the staff prevent the resident from digging her thumb into her skin, the nurse stated that they would roll her finger with gauzes and then rolled her hand with gauze to prevent the pressure from forming. During an interview on 07/10/24 at 3:35 PM, LPN2 confirmed R1 had a dressing applied to her left hand on 07/09/24. LPN2 stated she did not remove R1's dressing to her left hand to look at (examine/assess) why the dressing was applied. LPN2 stated the dressing did not have a date it was applied and did not have any initials of who applied the dressing. LPN2 confirmed prior to this date (07/10/24) there was no physician order for a dressing to be applied to R1's left pinky. During an interview on 07/10/24 at 3:37 PM, the Nurse Manager (NM) stated she was first notified this morning (07/10/24) R1's left pinky had reopened. The NM stated if the nursing staff was aware R1's left pinky finger had reopened yesterday (07/09/24), then she should have been notified of it yesterday. The NM verified there was no physician's order for any type of treatment or dressing yesterday. The NM verified the resident's physician was not notified yesterday and there should not have been any type of treatment or dressing applied to R1's pinky finger yesterday without an order from the physician. During an interview on 07/10/24 at 3:55 PM, when asked about R1 having a treatment initiated and completed for a pressure injury to her left pinky finger without a physician's order, the Administrator stated it was her expectation the nursing staff would have followed the facility's policy. The Administrator stated it was her expectation the nursing staff would have followed the facility's policy related to notifying the physician when R1's pressure reopened. During an interview on 07/10/24 at 4:02 PM, the DON stated it was her expectation the nursing staff would have followed the facility's polices related to R1's physician being notified and the treatment being started without a physician's order. (Cross reference F688) (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the facility's policy titled, Wounds: Treatment of Pressure and Non-Pressure Injuries, including Staging and Documentation, revised 10/2023 revealed Purpose: To provide guidelines for use in wound assessment, treatment, and documentation . It is the responsibility of the Director of Nursing to oversee this policy procedure. Policy: . A physician's order is required for ALL wound treatment . B. Assessment/Documentation: 1. Any wound is to be assessed by a licensed nurse or licensed practitioner. The location, stage, size, odor, undermining, tunneling, exudates, necrotic tissue, and presence of absence of granulation tissue, peri-wound and wound edge description should be noted and documented in the resident's medical record at least weekly. Wound assessment documentation should be completed for pressure injuries and recommended for any other skin issues of concern. a. Location: Describe the precise location of the wound in anatomical terms. b. Staging: (Pressure Injuries) . 3. Stage 2 Pressure Injury: Partial thickness skin loss with exposed dermis. The wound bed is viable, pink, red, moist, and may present as an intact or ruptured serum-filled blister . 4. Stage 3 Pressure Injury: Full thickness tissue loss. Full-thickness loss of skin in which adipose (fat) is visible in the ulcer granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible . c. Size: Measure the wound in centimeters including the length, width, and depth. Measure wound from 'healed margins to healed margins' vs. 'edge to edge.' . d. Odor: Describe the odor of the wound as none, mild, or foul (after cleaning). e. Color: Describe the color of the involved area. Note options for documentation here include describing the wound bed (including granulation tissue, slough, or eschar) in terms of color such as pink, red, yellow, white, black, or brown and estimate percentage of colors. f. Surrounding Tissue (Periwound): Assess the surrounding tissue and document the involved areas i.e., inflammation, maceration, or wet wound edges, tenderness, warm or cool to touch, skin turgor, hypertrophic/callused/thickened, or any other finding. g. Drainage: Describe the type, amount, and color of the drainage (exudates). Examples: yellowish green, gray, serosanguinous, etc. - amount: zero, small, moderate, and large. h. Pain: Describe pain related to the wound and incorporate interventions to reduce pain in the care plan. Document interventions and outcomes in the medical record . C. Monitoring of Wounds: . When a wound is present monitoring should include the following: an evaluation of the injury if no dressing is present, an evaluation of the status of the dressing, if present (whether it is intact, if there is drainage, is it or is it not leaking) . All dressings will be dated and initialed by the nurse apply the dressing . F. Documentation. It is critical that all caregivers document their observations and activities. For example, CNAs are critical to the process by reporting abnormal skin observations, . Nurses also have a variety of documentation responsibilities as indicated throughout and are critical to the process of documenting interventions that have been taken to AVOID pressure injuries . 'Avoidable' means that the resident developed a pressure injury, and that the facility did not do one or more of the following: . Define and implement interventions consistent with recognized standard of practice. Monitor and evaluate the impact of the interventions. Revise the interventions as appropriate . Documentation is key to show that everything is being done to prevent those avoidable pressure injuries and heal pressure injuries . (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the facility's policy titled, Skin Integrity, Assessment and Prevention of Wounds/Other Skin Conditions, revised 09/2022 revealed, Purpose: To prevent avoidable skin breakdown and pressure injuries, provide guidelines for the treatment of impaired skin and guidelines for documentation . Responsibility: It is the responsibility of the Nurse Manager to oversee this policy . Policy: All resident's will be assessed for the risk of skin breakdown. Risk factors identified will be evaluated. Interventions will be developed and implemented to minimize or stabilize the risk. Interventions will be care planned. Practice: . II. Prevention. The following guidelines, which should be implemented based on medical history and physical assessment using an interdisciplinary team approach . Abnormal findings will be assessed by a licensed nurse and appropriate interventions and documentation completed by the nurse . 4. Pressure Reduction. Appropriate pressure reducing positioning devices should be used . Contact Rehabilitation Services for evaluation of seating and positioning devices and orthotic devices . E. All assessments, interventions, and outcomes must be documented in the medical record . Review of the facility's policy titled, Condition Changes, Incidents, Injuries-Reporting of, revised 01/2023 revealed Purpose: To provide an orderly process for reporting changes in condition, incident or injuries involving residents . Responsibility: It will be the responsibility of the licensed nurses to know and follow this policy . When reporting changes in condition or incidents, the following procedure should be followed: 1. Evaluate symptoms and/or injury. Complete overall head to toe assessment . Document assessment and findings on SBAR [Situation, Background, Assessment, and Recommendation] .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36898 Based on observation, interview, record review, and review of the facility's policy, the facility failed to ensure safe water temperatures in residents' bathrooms/personal sinks were maintained for two of 23 sampled residents (Resident (R) 51 and R17). The residents' bathroom sink hot water temperatures were greater than 120 degrees Fahrenheit (F). This failure placed both residents at risk for skin irritation, redness, pain, and burns. Findings include: 1. Review of R51's untitled and undated face sheet, provided by the facility, revealed the resident was most admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease and dementia. Review of R51's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/06/24, provided by the facility, revealed the facility assessed a Brief Interview of Mental Status (BIMS) score could not be obtained on the resident. The facility assessed R51 had short and long term memory problems, and was severely cognitively impaired when making decisions regarding tasks of daily life. The facility assessed the resident to need partial to moderate assistance for hygiene and could independently use her wheelchair. During an interview on 07/07/24 at 12:33 PM, when asked if her water gets hot, R51 stated, Hot? It blows it out hot. R51 stated she independently used the sink to wash her hands. When asked what she did when the water temperature got hot, the resident stated she hurried up. During an observation and interview on 07/07/24 at 1:12 PM, the Administrator in Training (AIT) took the water temperature and stated it was 130 degrees F. During an interview on 07/07/24 at 5:48 PM, Licensed Practical Nurse (LPN) 3 stated R51 was able to get to the bathroom sink in her wheelchair independently. LPN3 stated R51 had the ability to turn the hot water on; however, she did not think she would have the cognitive ability to adjust the water temperature to a warm temperature. During an interview on 07/07/24 at 6:00 PM, Certified Medication Tech (CMT) 2 stated R51 could make it to the bathroom sink independently and turn on the water. CMT1 stated the resident would not know how to turn on the water to adjust it to a warm temperature. 2. Review of R17 untitled and undated face sheet, provided by the facility, revealed the resident was most recently admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease and dementia. Review of R17's quarterly MDS with an ARD of 06/19/24, provided by the facility, revealed the facility assessed the resident to have a BIMS score of 11 out of 15 which indicated the resident was moderately cognitively impaired. The facility assessed R17 needed partial to moderate assistance with hygiene, and independently used the wheelchair. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265756	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2024
NAME OF PROVIDER OR SUPPLIER Bethesda Southgate		STREET ADDRESS, CITY, STATE, ZIP CODE 5943 Telegraph Road Saint Louis, MO 63129	

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 07/07/24 at 1:11 PM, the AIT took the water temperature in R17's bathroom and confirmed the temperature was 128.1 degrees F. During an interview on 07/07/24 at 5:48 PM, LPN3 stated R17 could get to the bathroom sink without assistance using her wheelchair. LPN3 stated the resident could turn the water on, and if it was too hot, she would pull her hand back; however, she would need someone to adjust the water temperature for her. During an interview on 07/07/24 at 6:00 PM, CMT2 stated R17 had the ability to get to the sink independently in her wheelchair but she would not have the cognitive ability to adjust the water if it was too hot. During an interview on 07/07/24 at 2:45 PM, the Administrator stated any water temperature above 120 degrees F was out of the regulatory range. When asked about the sink water temperatures that were above 120 degrees F, the Administrator stated it was important to get the temperatures down below the regulatory range for the safety of the residents. When asked what safety concerns there were for residents using sinks with water temperatures above 120 degrees F, the Administrator stated residents could receive skin injuries such as burns. During an interview on 07/07/24 at 2:49 PM, the Maintenance Director stated he came in today and adjusted the water temperature coming from the hot water tank to the long term care (LTC) mixing valve from 130 degrees F to 117 degrees F. The Maintenance Director stated the hot water temperature of the residents' sinks should have been below 120 degrees F for the safety of the residents. During an interview on 07/07/24 at 3:44 PM, when asked how the hot water temperature setting got to 130 degrees F, the Maintenance Director stated I don't know. Review of the facility's water temperature logs for the past six months revealed no documented water temperatures of 120 degrees F. Review of the facility's policy titled, Water Temperature Management, revised 07/2024 revealed . Purpose: To achieve the lowest potential for adverse impact of the safety and health of staff, residents, and visitors coming into the organization's facilities. Policy: The facility will insure [sic] that plumbing fixates that supply hot water and are accessible to the residents shall be thermostatically controlled so the water temperature at the fixture does not exceed one hundred twenty degrees Fahrenheit (120 F) .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265756	A. Building B. Wing	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethesda Southgate	5943 Telegraph Road Saint Louis, MO 63129

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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. 30687 Based on interview and record review, the facility failed to follow their infection control policy when staff failed to complete the annual one step of the employee tuberculosis (TB, a potentially serious infectious bacterial disease that mainly affects the lungs) screening tests for three employees. The census was 110 with 31 in state license beds. Review of the facility's Tuberculosis Screening and Testing of Employees and Volunteers, dated May 2024, showed the following: -Purpose: To establish guidelines for consistency in tuberculosis screening and testing for new employees and volunteers and annual testing and assessment for existing employees and volunteers. -Scope: Level I policy affecting all employees and all volunteers who work ten or more hours weekly in long term care communities which includes skilled nursing. -Responsibility: It is the responsibility of the Infection Preventionist/Employee Health Nurse or designee to perform annual health screenings. -There was no documentation regarding an annual one step tuberculin skin tests (TST). 1. Review of Staff Member A's employee file, showed the following: -Hire date: 1/22/2001; -No documentation of an annual one step. 2. Review of Staff Member B's employee file, showed the following: -Hire Date 3/21/2011; -No documentation of an annual one step. 3. Review of Staff Member C's employee file, showed the following: -Hire Date: 2/13/2023; -No documentation of an annual one step. 4. During an interview on 7/15/24 at 12:51 P.M., the Director of Nursing (DON) said an annual health screening is completed for employees employed more than a year. The DON said this started in October, 2023. The corporate office changed the policy in line with the federal guideline. The DON said she did not know a one step was still required.