STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265764	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethesda Dilworth	9645 Big Bend Blvd Saint Louis, MO 63122

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 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. 30869 Based on interview and record review, the facility failed to provide an appropriate immediate discharge letter to one of four sampled residents (Resident #1). The letter failed to contain the effective date of discharge, specific location to where the resident was transferred and discharged , failed to provide information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request, along with the failure to inform the resident he/she can return to the facility if an appeal is filed. Additionally, the Long-Term Care Ombudsman's office address was incorrect, and no email address was listed. The census was 147. Review of the facility's Discharge/Transfer of a Resident policy, dated 12/2022, showed: -The facility complies with federal regulations to permit each resident to remain in the community, and not transfer or discharge the resident unless: -The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the community; -The safety of the individuals in the community are endangered due to the clinical or behavioral status of the resident; -Contents of the transfer/discharge notice must include: -The reason for transfer or discharge; -The effective date of transfer or discharge; -The location to which the resident is transferred or discharged ; -An explanation of the right to appeal the transfer or discharge to the State, including: -The name; -The address (mailing and email); -The telephone number of the State entity which receives such requests; (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; -The name, address (mailing and email), and telephone number of the Office of the State Long-Term Care Ombudsman. Review of Resident #1's face sheet, showed his/her diagnoses included unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety and osteoarthritis left shoulder replaced with left artificial shoulder joint and admission for orthopedic aftercare. Review of the resident's Discharge Assessment-Return Anticipated, Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/13/24, showed: -Intact cognition; -No behavioral symptoms; -No rejection of care; -Pain intensity, on scale of 0-10, was 8; -High risk opioid drug class; -Diagnoses included orthopedic condition, hypertension (high blood pressure), dementia and anxiety disorder. Review of the resident's undated Resident Profile Report (plan of care), showed it did not identify the resident had a history of psychotic disturbance, mood disturbance, anxiety, or aggressive behavior. It showed the resident had periods of agitation regarding his/her pain medication changes made by the physician. The resident had periods of trying to block people from entering his/her room. Staff were to remind the resident to keep his/her room accessible for safety. Review of the resident's Situation-Background-Assessment-Recommendation (SBAR, a form completed by nurses, regarding important resident information/condition, to facilitate and increase the probability of effective, accurate, communication between health care professionals), dated 2/13/23 at 12:53 P.M., showed: (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-At 8:15 A.M., the resident was barricading his/her door and said he/she only wanted to talk to his/her physician. The resident's facility physician was called and said he would be at the facility shortly. The resident was told his/her physician would be there shortly to talk with him/her. The resident said he/she was leaving and called a taxi. The resident refused to open the door. The resident's physician arrived and they (the nurse and the physician) visited with the resident. The resident said he/she was leaving against medical advice (AMA). The resident's ex-spouse was called and informed the resident wanted to leave. The ex-spouse said neither he/she, nor any other family member, was going to pick the resident up. The resident then stated he/she wanted to leave with the police, because he/she was mad and did not want to pay for the taxi, so the resident called the police. The police arrived, were informed of the resident's behaviors, and shown the sharp object that was in resident's hand while he/she was lying in bed and demanding the lights stay off. The sharp object was later found in the resident's sink. The resident was up and walking around his/her room the entire morning. The resident's physician gave the order for a psychiatric evaluation and for transport to a psychiatric hospital. The resident was escorted out of the building by the police, and the Emergency Medical Technicians (EMTs), to ensure the safety of the other residents in the facility. Discharge paperwork was sent with the EMTs. The resident got onto the stretcher willingly, was taken to the ambulance, and was transported off campus; -Behaviors Exhibited at 8:15 A.M.: Agitated, delusional, disruptive social interaction, reckless, uncooperative, and verbally aggressive toward others; -Behaviors Exhibited at 9:15 A.M.: Agitated, anxious, hallucinating, inappropriate, verbally aggressive toward others; -Behaviors Exhibited at 9:30 A.M.: Delusional, destructive, reckless, and restless; -Behaviors Exhibited at 10:00 A.M.: Destructive, hostile, inappropriate, and uncooperative. During an interview on 3/7/24 at 12:30 P.M., the Administrator and Director of Nursing said the resident was admitted to their rehabilitation unit for physical therapy on 2/7/24, after having his/her left shoulder replaced with an artificial shoulder. They later discovered the resident had a history of substance abuse. The facility physician discontinued the resident's oxycodone (a strong narcotic for pain control) on 2/12/24. There were remaining pain control orders for Tramadol and Tylenol. The next morning, the resident wanted his/her oxycodone and became increasingly agitated, aggressive, and erratic, demanding to speak with the physician. The resident tried to throw a chair at staff and broke his/her plastic incentive spirometer (a handheld medical device that measures the volume of your breath), thereby obtaining a small shard of the plastic to use as a weapon. The resident kept saying he/she had his/her own stuff (medications) to take and called a cab to take him/her home. The resident then called the police and his/her ex-spouse to take him/her home. The resident's behavior was erratic and symptomatic of acute psychosis. Five police officers ended up on the scene. The facility physician did a direct, involuntary admission to the psychiatric hospital. The resident was admitted to the hospital. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's hospital behavioral health intake assessment, dated 2/13/24 at 5:00 P.M., showed the resident presented to the hospital from the nursing home's rehabilitation facility for a psychological evaluation. The resident was alert, oriented, and accompanied by an adult offspring. Chart review showed the resident had a history of anxiety, depression, alcohol abuse, and recent left shoulder replacement. Nursing home staff reported to EMS the resident had barricaded him/herself in his/her room and was found in possession of a sharpened piece of plastic. The resident denied having a sharp piece of plastic and said it was a broken spirometer piece with a sharp edge that he/she noticed in the room. Nursing home staff said the resident picked up a chair to throw at staff, which the resident denied. The nursing home was not allowing the resident to return. The hospital assessment showed the resident was agitated, with flat affect and poor eye contact. The resident answered with one or two words unless talking about how the nursing home staff did not give medications to him/her when asked. The resident's family member said the resident was not formally diagnosed with dementia but had similar episodes of agitation and confusion over the past year, seemingly worst after hospitalization s for other medical concerns. The family member said the resident was also ordering medicine off the internet and had some pink pills at his/her house, which he/she wanted to obtain. The family member said the resident had prescriptions for Tramadol and other medications, was not taking Lyrica (a prescription medication for nerve pain) as prescribed, and was not taking his/her antidepressant. The family member said the resident slept all day, was awake all night, and would take six Tylenol P.M. pills, all at once, to sleep. The longer the resident stayed in a healthcare setting, the more uncooperative and worse he/she would get. The family member said the resident was not safe at home. The resident's emergency department physician agreed to admit the resident due to imminent danger to him/herself and others. Review of the facility's undated discharge form, used for the resident's immediate discharge, showed it did not include the following: -A title, indicating it was a discharge notice; -The effective date of discharge; -The location, which the resident was discharged to; -Information on how to obtain an appeal form; -Information on how to obtain assistance with completing the appeal form; -Information on how to submit the appeal form for a hearing request; -Information informing the resident he/she could return to the facility if an appeal was filed; -The correct office address, and email address, of the Long-Term Care Ombudsman's office. During an interview on 3/13/24 at 3:23 P.M., the Administrator said the location which the resident was discharged to was not applicable because the resident was going to the hospital. The resident was there for therapy and was not in need of long-term care. The information on how to appeal, to stay in the facility, was not applicable because it was not safe to keep the resident in the facility. The Administrator did not know, at the time of the resident's discharge, that the Ombudsman's office address had changed. (continued on next page)

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