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	05/23/2024

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46970 Based on interview and record review, the facility failed to follow their abuse and neglect policy by not reporting timely after an incident involving one resident (Resident #1) and two staff, who performed an improper transfer which resulted in the resident sustaining a comminuted tibial plateau fracture (a break in the lower bone below the knee that breaks into the knee joint and is displaced and not aligned) involving the medial (the bony surface on the top of the shin bone that corresponds to the big toe) and lateral (the surface that corresponds to the pinky toe) tibial plateau without significant displacement. The sample size was 3. The census was 149. Review of the facility's Resident Abuse, Neglect, and Exploitation policy and procedure, revised ,d+[DATE], showed: -Purpose: To provide guidelines for identifying, investigating, and reporting resident abuse, neglect, and exploitation, (which includes misappropriation of the resident's personal property) including any reasonable suspicion of a crime directed toward the resident; -Responsibility: It is the responsibility of the Administrator of each residence to monitor compliance of this policy. Department Managers and Supervisors must know, understand, and enforce this policy. All employees of the facility must know, understand, and abide by this policy; -Abuse Definitions: Serious bodily injury: An injury involving extreme physical pain; involving protracted loss (serious bodily harm that results either in a diminished quality of life for the victim or their death); requiring medical intervention such as surgery, hospitalization physical rehabilitation; -Covered individual: Anyone who is an owner, operator, employee, manager, agent, or contractor of the facility; -The following procedure for investigation and reporting a suspected or actual abuse/neglect situation will be adhered to by all employees; -Procedure for complaint of/or suspected/observed resident abuse/neglect/exploitation or who discovers, and unexplained incident/injury should make an immediate report to his/her Administrator and disrupt any acts of abuse; (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-An investigation shall be initiated immediately. Any allegation must be fully investigated and self-reported to an appropriate state agency; -Each covered individual shall report immediately, but not later than two hours after forming the suspicion, if the events that cause the suspicion involve abuse or result in serious bodily injury, or not later than twenty-four (24) hours if the events that cause the suspicion do not result in serious bodily harm; -Upon completion of the investigation, the following actions may be warranted: -Appropriated disciplinary action of the responsible employee, up to and including discharge, shall be taken. Any disciplinary action taken shall be fully documented; -The final results of the investigation shall be reported within five (5) working days of the initial notification of DHSS (Department of Health and Senior Services). Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated [DATE], showed: -Moderate cognitive impairment; -Sit to Stand: Substantial/Maximal assistance; -Chair/bed to chair transfer (The ability to transfer to and from a bed to a chair or wheelchair): Substantial/Maximal assistance; -Diagnosis included: Seizure Disorder (Nerve cell activity in the brain is disturbed) or Epilepsy (A chronic neurological disorder that causes a person to have two or more unprovoked seizures that occur more than twenty-four (24) hours apart), Muscle weakness (generalized), weakness. Review of the resident's care plan, revised [DATE], showed: -Intervention: Require extensive two (2) person assistance with transfers using stand up lift; -Goal: Maintain independence and have needs met to my satisfaction with assistance; -Focus/Problem: At risk for falls related to decreased mobility. Review of the emergency resident encounter documentation, dated [DATE] at 12:41 P.M., showed: -Lower extremity problem (from nursing home-was being transferred to bed and right leg got caught; concerned for tibial fracture); -Resident being evaluated for a complaint of fall with resultant right lower extremity pain, especially right knee pain, which occurred last night; (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Findings: Severe bony demineralization. Acute, nondisplaced intra-articular tibial plateau fracture. Fracture lines involve both the medial and lateral tibial plateaus and extending anteriorly through the midline; -Final Impression: -Closed fracture of right tibial plateau; -Fall, initial encounter; -Acute pain of right knee. Review of the facility's investigation, showed: -On [DATE], the DON (Director of Nursing) spoke with Certified Nurse Assistant (CNA) A who said he/she and CNA B had finished the resident's shower on the evening of [DATE]. When they went to transfer the resident to bed, the sit to stand battery did not have a charge. The resident was upset when they asked him/her to wait, so they did an assist of two transfer; -Performance management conference form, dated [DATE], showed: -CNA A; Reason for conference: Failure to render a service within the scope of duties as defined by the employee job description; -On [DATE], the DON spoke with CNA B. CNA B said after the resident's shower, they attempted to get the sit to stand for a transfer and the battery would not work. The resident was upset when asked to wait so they did an assist of two transfer. He/She went to LPN (Licensed Practical Nurse) C to tell him/her they transferred the resident with a two person assist; -Performance management conference form, dated [DATE], showed: -CNA B; Reason for conference: Failure to render a service within the scope of duties as defined by the employee job description; -On [DATE], the Administrator spoke with the resident regarding the incident on [DATE]. The resident reported he/she wanted to go to bed and told the CNA. The CNA told him/her the battery died during a shower he/she was giving, and the resident had to wait for it to charge. The resident stated he/she told the CNA he/she wanted to go to bed, and he/she didn't want to wait. The resident stated that he/she asked the CNA if he/she would just put him/her to bed. The CNA left the room and came back with another CNA, and they transferred him/her to bed. The resident stated when he/she was in bed, he/she started to feel his/her leg was hurting. The resident said he/she told the nurse; -No documentation to show the facility notified DHSS of the incident or injury. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 1:05 P.M., the resident said while staff were transferring him/her back to bed, the resident said CNA B and another staff put him/her back to bed by picking him/her up together. The resident said CNA B was one staff, but he/she didn't know the other staff name. The resident said his/her leg got caught under the bed as he/she was being turned into the bed. He/She kept screaming and telling CNA B and the other staff member his/her leg was stuck, but they continued to put him/her to bed. The resident was hurt. His/Her right knee was hurt. Observation showed the resident pointed to his/her right knee. The resident said staff usually used the lift, so he/she didn't know why they picked him/her up and tried to put him/her in bed. He/She said the staff didn't realize his/her foot was caught until after he/she was in bed. During an interview on [DATE] at 10:42 A.M., CNA A said he/she and CNA B didn't drop the resident. He/She said the resident used a sit to stand lift. They used the sit stand lift that day, but the battery went dead. CNA A and CNA B charged the battery, but it didn't work. He/She told the resident the battery was dead, but the resident demanded to be put in bed. Once the resident sat on the bed, CNA A said the resident said, Oh you hurt my leg. The resident didn't scream or yell. CNA A said he/she didn't see what the resident's leg was caught on. The CNA's looked at the resident's legs and didn't see anything. He/She asked if the resident was ok and then told the nurse after the transfer that the resident said his/her leg hurt. CNA A said he/she didn't talk to the nurse directly about what took place. During an interview on [DATE] at 11:02 A.M., Licensed Practical Nurse (LPN) C said he/she knew the resident and was familiar with his/her care. He/She said the resident used a sit to stand. CNA B came up to him/her and said they had to transfer the resident like a two person. LPN C asked CNA B why they transferred the resident without the sit to stand. When he/she again asked CNA B why they did the transfer without the sit to stand again, CNA B threw up his/her hands and walked away. CNA B never came back to say the resident had been hurt. During an interview on [DATE] at 3:07 P.M., the Administrator and DON said the resident was hurt during a transfer. He/She had a fracture just above the knee. They said the resident got x-rays and was sent out to the hospital. The Administrator said the resident was a sit to stand transfer at the time of the fall. The staff involved received disciplinary action. She didn't report it to DHSS because the incident was witnessed, and it was not an unknown injury. MO00234994

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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 - 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** 46970 Based on interview and record review, the facility failed to provide adequate supervision for one resident (Resident #1) who required staff assistance with transfers and mobility when going to bed. On [DATE], after the resident became adamant about staff putting him/her to bed, staff removed the resident from a sit to stand lift (a medical device that assists individuals with limited mobility in standing up from a seated position) and performed a 2-person assist transfer. The resident's right foot was caught under the bed during the transfer and sustained a comminuted tibial plateau fracture (a break in the lower bone below the knee that breaks into the knee joint and is displaced and not aligned) involving the medial (the bony surface on the top of the shin bone that corresponds to the big toe) and lateral (the surface that corresponds to the pinky toe) tibial plateau without significant displacement. The sample size was 3. The census was 149. Review of the facility's Mechanical Lifts, Use of policy and procedure, revised ,d+[DATE], showed: -Purpose: To establish proper guidelines for safely moving or transferring a resident from one place to another; -Responsibility: It is the responsibility of all nursing personnel to follow this policy; -Policy: Resident's transfer needs should be assessed upon admission, quarterly and PRN (as needed). Review of the facility's Condition Changes, Incidents, Injuries-Reporting of policy and procedure, revised , d+[DATE], showed: -Purpose: To provide an orderly process for reporting changes in condition, incident or injuries involving residents; -Policy: It is the facility's policy to report condition changes, incidents or injuries involving residents; -Practice: -Serious incidents, i.e., fractures, head injuries, uncontrolled bleeding or acute changes in resident conditions are reported to the physician at the time of occurrence. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated [DATE], showed: -Moderate cognitive impairment; -Sit to Stand: Substantial/Maximal assistance; (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-Chair/bed to chair transfer (The ability to transfer to and from a bed to a chair or wheelchair): Substantial/Maximal assistance; -Diagnosis included: Seizure Disorder (Nerve cell activity in the brain is disturbed) or Epilepsy (A chronic neurological disorder that causes a person to have two or more unprovoked seizures that occur more than twenty-four (24) hours apart), Muscle weakness (generalized), weakness. Review of the resident's physical therapy plan of care, dated [DATE], showed: -Treatment Diagnosis: Weakness; -Precautions: Transfers with standup lift or pivot (the person bears at least some weight on one or both legs and spins to move their bottom from one surface to another). Review of the resident's care plan, last updated on [DATE], showed: -Focus: At risk for falls related to decreased mobility; -Goal: Maintain independence and have needs met to resident's satisfaction with assistance; -Intervention: Require extensive two (2) person assistance with transfers using stand up lift. Review of the resident's physician orders, showed no order for transfer status. Review of the emergency resident encounter documentation, dated [DATE] at 12:41 P.M., showed: -Lower extremity problem (from nursing home-was being transferred to bed and right leg got caught; concerned for tibial fracture); -Resident being evaluated for a complaint of fall with resultant right lower extremity pain, especially right knee pain, which occurred last night; -Findings: -Severe bony demineralization. Acute, nondisplaced intra-articular tibial plateau fracture. Fracture lines involve both the medial and lateral tibial plateaus and extending anteriorly through the midline; -Final Impression: -Closed fracture of right tibial plateau; -Fall, initial encounter; -Acute pain of right knee. Review of SBAR (Situation, Background, Assessment, Recommendation, assessment tool), dated [DATE], showed: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-Situation - Pain -New Pain Evaluation: Yes; -Pain Present: Yes, actual, or suspected pain; -Primary Pain Location: Knee; -FACES Pain Scale (A self-report measure of pain intensity) Rating: 6 = Hurts even more; -FACES Pain Score Rating: 6; -Appearance and Evaluation Findings: Appearance, Evaluation Comments: Resident had rung call light and asked for something for pain. When asked about his/her pain, resident stated he/she has pain in his/her right knee. Resident stated that when being transferred into bed, his/her right foot was caught under the bed and then he/she felt a pain in his/her right knee. Upon assessing resident, his/her right knee is warm and appears slightly swollen; -11:40 A.M., x-ray returned with possible tibia (shin bone) fracture. New orders to send the resident to ER (emergency room). Review of the facility's investigation, showed: -On [DATE], the DON (Director of Nursing) spoke with Certified Nurse Assistant A. CNA A said he/she and CNA B had finished the resident's shower on the evening of [DATE]. When they went to transfer the resident to bed, the sit to stand battery did not have charge. The resident was upset when they asked him/her to wait, so they did an assist of two transfer; -Performance management conference form, dated [DATE], showed: -CNA A; Reason for conference: Failure to render a service within the scope of duties as defined by the employee job description; -On [DATE], the DON spoke with CNA B. CNA B said after the resident's shower, they attempted to get the sit to stand for a transfer and the battery would not work. The resident was upset when asked to wait so they did an assist of two transfer. He/She went to LPN (Licensed Practical Nurse) C to tell him/her they transferred the resident with a two person assist; -Performance management conference form, dated [DATE], showed: -CNA B; Reason for conference: Failure to render a service within the scope of duties as defined by the employee job description. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-On [DATE], the Administrator spoke with the resident regarding the incident on [DATE]. The resident reported he/she wanted to go to bed and told the CNA. The CNA told him/her the battery died during a shower he/she was giving, and the resident had to wait for it to charge. The resident stated he/she told the CNA he/she wanted to go to bed, and he/she didn't want to wait. The resident stated that he/she asked the CNA if he/she would just put him/her to bed. The CNA left the room and came back with another CNA, and they transferred him/her to bed. The resident stated when he/she was in bed, he/she started to feel his/her leg was hurting. The resident said he/she told the nurse. During an interview on [DATE] at 1:05 P.M., the resident said his/her leg got caught under the bed. He/She kept screaming and telling them his/her leg was stuck but they kept putting him/her to bed. He/She was hurt. His/Her right knee was hurt. Observation showed the resident pointed to his/her right knee. The resident said staff usually used the lift, so he/she didn't know why they picked him/her up and tried to put him/her in bed. He/She said the staff didn't realize his/her foot was caught until after he/she was in bed. The resident said CNA B was one staff, but he/she didn't know the other staff's name. He/She said CNA B wasn't there and he/she usually worked evenings. During an interview on [DATE] at 12:51 P.M., the DON said she didn't have a sit to stand assessment form for the resident. She said therapy was going to send over whatever notes they had. She saw the facility's policy said the resident must be assessed initially before using the sit to stand and routine intervals thereafter. Therapy makes a recommendation and they can follow it, but as a nurse, she can down grade the recommendations but can not ever go above the recommendations and the same thing for hospital recommendations. During an interview on [DATE] at 3:07 P.M., the Administrator and DON said the resident was hurt during a fall and had a fracture just above the knee. The Administrator said the resident could use a sit to stand or pivot for transfers. During an interview on [DATE] at 10:42 A.M., CNA A said he/she and CNA B didn't drop the resident. He/She said the resident used a sit to stand lift. They used the sit stand lift that day, but the battery went dead. CNA A and CNA B charged the battery, but it didn't work. He/She told the resident the battery was dead, but the resident demanded to be put in bed. CNA A got another staff to help transfer the resident. They angled the resident towards his/her bed and put on the gait belt. No sit stand was used. He/She had the resident's upper body and stood on the left side of the bed. CNA B was on the right side. Once the resident was sitting on the bed, CNA B pivoted his/her shoulders, and he/she pivoted the resident's legs into bed. Once the resident sat on the bed, CNA A said the resident said, Oh you hurt my leg. The resident didn't scream or yell. CNA A said he/she didn't see what the resident's leg was caught on. The CNA's looked at the resident's legs and didn't see anything. He/She asked if the resident was ok and then told the nurse after the transfer that the resident said his/her leg hurt. CNA B went to tell LPN C. CNA A didn't understand what happened and didn't get vital signs because he/she didn't think it was severe. CNA A asked the resident again if he/she was ok and the resident said yes. The resident didn't show any indications that anything was wrong. When he/she came in to work the next day, the resident had told the night nurse, LPN E, that his/her leg was hurt. The resident told LPN E because he/she was afraid to tell them. The resident told LPN E his/her leg hurt. LPN E called the physician to get orders for an x-ray because the resident was in pain. CNA A said he/she didn't talk to LPN C directly. He/She said the resident didn't fall. If he/she had fallen, it would have taken more than the two of them to get the resident up because the resident was dead weight. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 11:02 A.M., LPN C said he/she knew the resident and was familiar with his/her care. He/She said the resident used a sit to stand. LPN C said he/she didn't talk to CNA A that day about the resident at all on [DATE]. CNA B came up to him/her and said they had to transfer the resident like a two person. LPN C asked CNA B, why they transferred the resident without the sit to stand. When he/she again asked CNA B why they did the transfer without the sit to stand again, CNA B threw up his/her hands and walked away. LPN C said the facility had a lot of sit to stand lifts in the building and staff could have gotten one from somewhere else. LPN C told CNA B he/she shouldn't have picked the resident up without the sit to stand. CNA B never told him/her what happened to resident or anything about pain. The resident told him/her that CNA B two personed me. LPN C asked the resident why he/she would let someone do that. It's not safe. LPN C and the Staffing Coordinator, who was working as a Certified Medication Technician (CMT) that shift, said CNA B never came back to tell the resident had been hurt. During an interview on [DATE] at 11:50 A.M., the Staffing Coordinator said he/she worked over as a CMT on the evening the event happened with the resident. He/She was sitting at the desk with LPN C ordering medications. CNA B walked to the desk. LPN C was doing an admission. CNA B said he/she and CNA A two person the resident into bed. LPN C asked CNA B what did he/she say. CNA B repeated him/her and CNA A performed a two person transfer to put the resident in bed. CNA B said the battery was dead. That didn't make since because they could have gotten a battery from another floor. CNA B got mad at them for telling him/her he/she could have gotten a battery from another floor. CNA B huffed and walked off. He/She didn't come back to the desk to tell the resident was hurt or had an injury. CNA B transferred the resident with CNA A because the resident was adamant about getting into bed. When the Staffing Coordinator went to pass medications on a different day he/she saw the resident with a knee immobilizer (device used to maintain stability of the knee). The resident told him/her CNA B and CNA A transferred him/her with a two-person transfer. He/She didn't know why the resident had it on. The Staffing Coordinator said he/she went to tell LPN C about the immobilizer on the resident's leg. LPN C went to look at the log and saw the resident went out over the weekend to the hospital and came back with that on his/her leg. During an interview on [DATE] at 2:21 P.M., the Administrator said she expected staff to follow the mechanical lift and all other policies. She expected staff to follow the resident's plan of care and use a sit to stand lift during transfers. The Administrator expected staff to tell the nurse if the resident said he/she was hurt and if there was an incident, with or without injury. If nursing had been aware of the resident's injury, she expected staff to complete the required assessments. The Administrator said she felt like staff thought they provided care for the resident's needs. The DON said she had told staff many times to go to other floors to get batteries. The Administrator and DON said they were told the battery was dead and staff checked another battery for the sit to stand lift but it didn't work. They both said staff told them the resident was adamant about going to bed, so they put him/her to bed. If the resident would have had to sit in the wheelchair, he/she would have been upset. Once he/she became adamant about getting into bed, staff put the resident to bed. The Administrator could not say whether it would have been safer for the resident to sit and wait until the battery charged or to get one from another floor because either way, the resident would have been upset. MO00234994