| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265764 | A. Building<br>B. Wing | 03/19/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Bethesda Dilworth | 9645 Big Bend Blvd<br>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 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>Based on interview, observation, and record review, the facility failed to establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation when the shift change narcotic count was not completed and one of the narcotic count sheets for one resident was inaccurate (Resident #7). The sample was 14. The census was 152 with 130 in certified beds. Review of the facility's Inventory Control of Controlled Substances Policy, revised 8/2023, showed:-Purpose: This policy sets forth the procedures for inventory control of controlled substances and establishes guidelines for the investigation of missing medications;-Scope: Level 2 policy affecting contracted pharmacies, Human Resources, nursing staff, and nursing management;-Responsibility: It will be the responsibility of the nursing staff members to know and comply with this policy and procedure. It is the responsibility of the Director of Nursing (DON) to maintain, enforce, and monitor compliance of this policy;-Policy: Practice processes will be followed to establish inventory control of all controlled substances. An investigation will be conducted on all missing medications;-Practice: -Inventory Control:--All controlled substance delivered to the communities for an individual resident will immediately be added to Controlled Substance Log by the person signing the delivery receipt or electronically signed into the electronic dispensing device, if so designated;--Community should ensure that incoming and outgoing nurses and/or Certified Medication Technicians (CMTs) count all Scheduled II though V controlled substance and tramadol (pain medication) daily with both documenting verification on the Controlled Substance Log;-Investigation Guidelines for Missing Medications or Suspected Diversion:--It is the responsibility of all nursing staff members to immediately report all missing medications or suspected diversions to the Administrator or DON/designee. Examples of reporting instances could include the following:---Shift-to-shift count or daily reconciliation from electronic dispensing device does not correctly reconcile;---Improper controlled substance or as needed (PRN) documentation. Discrepancies noted on any controlled substance records. Review of Resident #7's medical record showed:-admission date 8/7/25;-Diagnoses included rheumatoid arthritis (chronic joint disease that causes pain and swelling), chronic kidney disease, heart failure, low back pain, and diabetes. Review of the resident's electronic Physician Order Sheet (ePOS), showed an order, dated 1/19/26, for oxycodone-acetaminophen (narcotic pain medication used for moderate to severe pain) 10-325 milligram (mg), one tab for pain every six hours at 0300, 0900, 1500, and 2100. Observation on 3/19/26 at 9:45 A.M., showed CMT B at the CMT medication cart. He/She opened the narcotic box, which showed the resident's card of oxycodone-acetaminophen 10-325 mg. CMT B removed one pill from the card and verified the card had a remainder of four pills. During an interview on 3/19/26 at 9:50 A.M., CMT B said he/she signs out the controlled substance medications as he/she goes along during the medication pass. He/She watches the resident take their medication. Counts of the narcotic medications are completed by staff at the beginning and end of each shift. Any discrepancies should be immediately reported to the nurse. If the medication card appears to be tampered with, CMTs are to notify the nurse and waste the medication. Observation on 3/19/26 at 9:56 A.M., showed CMT B administered the oxycodone-acetaminophen to the resident. CMT B did not sign the medication out of the controlled<br>(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 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | substance book prior to administering the medication to the resident.Observation and interview on 3/19/26 at 10:00 A.M., showed CMT B at the medication cart with the controlled substances book. He/She opened the book to sign out the oxycodone-acetaminophen he/she had just administered to the resident. The controlled substance sheet showed the previous quantity was six pills and CMT B signed out one, for a total of five pills. CMT B opened the narcotic box and verified four pills, not five, remained in the resident's medication card. He/She notified Licensed Practical Nurse (LPN) A, as LPN A walked by the cart, of the discrepancy. CMT B said he/she arrived late to the facility this morning and the medication counts were not done. During an interview on 3/19/26 at approximately 10:05 A.M., LPN A said counts should be done at the beginning and end of each shift. He/She assumed the counts were done this morning, but did not verify. During an interview on 3/19/26 at 11:16 A.M., the DON said she was aware of the discrepancy on the narcotic sheet. She expected counts to be completed by staff at the beginning and end of each shift. Narcotic medications should be signed out immediately upon removal. After each resident, the medication should be signed out immediately. During an interview on 3/19/26 at 12:00 P.M., the Administrator and DON said CMT B was sent for a drug screen and will be suspended pending investigation. They have started an investigation and have attempted to reach the night shift CMT. They expected CMT B to have counted with the nurse when he/she arrived at the facility this morning. During an interview on 3/19/26 at 3:30 P.M., the Administrator said she expected staff to follow policy. The narcotic counts should be done by staff before and after each shift. |