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	07/23/2025

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure on-going resident centered therapeutic activities were provided to residents in the evenings and weekends as an integral part of their psychosocial well-being. In addition, the facility failed to ensure activities were offered to all residents who wished to attend (Residents #140, #155 and #99). This deficient practice had the potential to affect all residents in the facility who wished to attend activites. The sample size was 25. The census was 145 with 126 in certified beds.1. During an interview on 7/23/25 at 8:31 A.M., the administrator said the Garden Terrace activity's calendar was the main calendar used for all activities in the facility. Review of the Garden Terrace Activity's Calendar, dated June 2025, showed: -Monday through Friday, no activities offered after 2:30 P.M.; -Saturdays, Catholic Mass at 10:30 A.M. in the chapel; -Sundays, no activities offered. Review of the Garden Terrace Activity's Calendar, dated July 2025, showed: -Monday through Friday, no activities offered after 3:00 P.M.; -Saturdays, Catholic Mass at 10:30 A.M., in the chapel; -Sundays, no activities offered except for non-Denominational church service on 7/20/25 at 2:00 P.M. 2. Review of Resident #140's Activity's Evaluation, dated 6/9/25, showed: -Activity Interest: BINGO, card games, hand crafts, sewing, social conversations with other residents. Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 6/11/25, showed: -Mild cognitive impairment; -No behaviors; -Very important for favorite activities and religious services; (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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnoses included high blood pressure, diabetes and paraplegia. During an interview on 7/17/25 at approximately 12:00 P.M., the resident said he/she was admitted about a month ago for rehab. He/she was interested in participating in activities but was never offered any activities outside of physical therapy. He/She was interested in playing BINGO and socializing with other residents. During an interview on 7/21/25 at 8:21 A.M., the resident said he/she was not offered activities over the weekend. If he/she had known there was a church service, he/she would have attended. Observation on 7/21/25 at 2:17 P.M., showed residents played BINGO in the activity's room. Resident #140 was not present. Observation and interview on 7/21/25 at 2:30 P.M., showed the resident sat in his/her wheelchair in his/her room and watched television. He/She said he/she did not know BINGO was going on at the present time and would have attended. 3. Review of Resident #155's medical record, showed: -admitted [DATE]; -Diagnoses included stroke, osteoarthritis, high blood pressure and altered mental status. Review of the resident's Activities Evaluation, dated 7/21/25, showed: -Activity Interest: BINGO and card games, painting, low impact exercise, books; -Activity Notes: He/she is a nice lady/man who can make his/her needs known. During an interview on 7/17/25 at 11:30 A.M. and 7/18/25 at 1:02 P.M., the resident said he/she enjoyed playing bingo and other card games. He/She also enjoyed church services. He/she was interested in activities, but had not been offered activities, but did not want to get anyone in trouble for not offering. During an interview on 7/21/25 at 8:17 A.M., the resident said he/she was not offered activities over the weekend. He/she did not know the facility had church services and would have enjoyed participating. Observation on 7/21/25 at 2:17 P.M., showed residents played BINGO in the activity's room. Resident #155 was not present. Observation on 7/21/25 at 2:28 P.M., showed the resident lay in bed. 4. Review of Resident #99's medical record showed: -Active diagnoses including high blood pressure, bipolar disorder (a psychological illness that causes unusual shifts in mood) and chronic obstructive pulmonary disease (COPD, lung disease); -Intact cognitive function. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's progress notes, showed a note from the Activities Department staff on 7/19/25 at 3:40 P.M., showed the resident had been interviewed concerning his/her lack of participation in facility activities, and the resident noted the lack of mentally stimulating activities. The resident noted he/she preferred math and science-based activities, and the facility did not seem to provide those types of activities. During an observation and interview on 7/18/25 at 9:31 A.M., the resident said he/she was admitted to the facility a couple years ago and was happy with care provided by the facility, but the facility did not have activities that felt stimulating to him/her. He/She enjoys math and science, and most of the activities are pretty simple. He/She was not aware of any specific activity plan set up for him/her by the activity department but had never been asked to participate in setting one up. During interview on 7/23/25 at 9:10 A.M., Certified Nursing Assistant (CNA) B said the resident does not often come out of his/her room during the day but is always pleasant with staff. When asked what type of activities the resident likes, CNA B said the resident liked coffee, and often asked for it in the afternoon, but was otherwise unaware of any activities the resident participated in. CNA B was unsure if the resident was on any 1-to-1 or resident-specific activities plan that may help develop activities the resident is interested in. 5. During a group interview on 7/21/25 at 1:04 P.M., six residents, whom the facility identified as alert and oriented, attended the group meeting. All six residents said activities were not offered during the weekends or in the evenings. The activities provided by the facility were good, but they wanted more. One resident said, we are bored on the weekends. All six residents said the facility could use activities on the weekends and during the evenings. 6. During an interview on 7/21/25 at 2:35 P.M., Activities Assistant A said there were four staff working in activities. At the moment, they did not have an Activity's Director. Activities staff worked Monday through Friday from 8:00 A.M. to 4:00 P.M. One staff will work the weekend, and they try to do activities during the weekend. Residents have expressed concern about the lack of activities during the weekend. During the weekend, CNAs were responsible for offering activities to residents. If they are busy with care, they may forget to offer activities. The residents were bored during the weekend. 7. During an interview on 7/23/25 at 11:38 A.M., the Administrator and Director of Nursing (DON) said residents should be offered activities. There should be on-going activities on the weekends and evenings.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interview and record review the facility failed to follow their grievance policy and procedure for residents and family members to voice grievances and prompt the facility to resolve grievances for one resident (Resident #9). The failure has the potential to affect all residents. The sample size was 13. The census was 146 with 119 in certified beds.Review of the facility's Resident and Family Grievances policy, revised, February 2025, showed: -Purpose: To establish written guidelines for the filing of residents' grievances and to ensure that appropriate investigation and actions are promptly taken; Customer feedback is an important source of information about an organization's performance; The verbal or written resident grievances received by staff, physicians, and administration provide vital information about improvement opportunities. -Definitions: A resident grievance is a formal or informal written or verbal complaint that is made to the facility by a resident, or the resident's representative, regarding the resident's care when the complaint is not resolved at the time by staff present and the complaint involves actual or potential abuse or neglect; If the complaint cannot be resolved at the time of the complaint by staff present, is postponed for later resolution, or, is referred to by other staff for later resolution, or requires investigation and or further actions for resolution, then the complaint is considered a grievance. A complaint is considered resolved when the resident and or resident representative are satisfied with the actions taken on their behalf; Grievance Official is the Administrator and or designee. The Grievance Official is responsible for overseeing the grievance process; receiving and tracking grievances through to their conclusion; leading any necessary investigation by the community; maintaining the confidentiality of all information associated with grievances; issuing written grievance decisions to the resident; and coordination with state and federal agencies as necessary in light of specific allegations; Prompt efforts to resolve include facility acknowledgement of a complaint and or grievance and actively working to resolve that complaint and or grievance. -Responsibility: It is the responsibility of the Grievance Official and all management staff to understand and enforce this policy; It is the responsibility of all employees to abide by this policy. -Resident rights: Residents have the right to voice a concern or grievance to the community or any other entity that hears grievances; A resident or family member should also report any grievances regarding retaliation or discrimination. The law prohibits owners, administrators, and staff of any long-term care facility from retaliating in any way when handling a resident concern. -Grievances: It is the policy of the facility to create an atmosphere in which its residents or family members feel free to voice concerns related to their care or living conditions without discrimination or reprisal (act of retaliation); Grievances are encouraged to be communicated to any staff member, an outside party, or the Grievance Official as soon as possible; Notification of dissatisfaction with resident care or service will be investigated promptly, corrective action will be taken where appropriate, and the results of the entire process including the details of the concern and actions taken, will be documented thoroughly and reported thorough the Quality Assessment and Performance Improvement (QAPI) Committee; -Procedure: A grievance may be filed: Completing the grievance form located in the designated areas in the facility by placing it in the grievance box and or submitting it to the Administrator; Anonymously in writing by placing in the grievance box or submitting a grievance via the facility compliance hotline; Reporting to facility staff; -Process: Grievances will be entered on a resident grievance report by the person receiving the report either on a paper or electronic submission and routed to the Grievance Official; Upon review of the grievance, the Grievance Official may initiate an investigation and route it to the appropriate department manager, if applicable, for follow up; Upon receiving the resident grievance, the supervisor or manager will gather pertinent documents and details for review; This includes contacting the resident or family to confirm previously provided information and to notify residents of their right to have assistance from an impartial non-affiliated advocate; The Grievance Official will review all information; Plans of action (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	may require consultation with various management levels, depending on the nature of the concern and/or validation; A written response to the grievance may be requested from all staff members or physicians who were named in the grievance, staff members who witnessed the situation, or staff members who can provide additional information; The facility should make prompt efforts to resolve the grievance; The resident and/or responsible party has a right to obtain a written decision regarding his or her grievance; A monthly grievance log of resident concerns and actions taken will be maintained by the Grievance Official. Review of the Resident #9's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 7/30/25, showed:-The resident is cognitively intact;-The resident uses wheelchair and walker;-The resident is dependent on assistance from staff for toileting, hygiene, bathing, lower body dressing, putting on and taking off footwear;-The resident requires partial to moderate assistance from staff to sit to stand, chair to bed to chair transfers, toilet transfers, and walking 10 feet;-The resident is occasionally incontinent of bowel and bladder;-Diagnoses included: Urinary tract infection (UTI), arthritis, malnutrition (poor nutrition), tremors, vertigo (dizziness), repeated falls, age-related physical debility, difficulty in walking, cognitive communication deficit, dysphagia (difficulty swallowing). Review of the resident's care plan, in use while the resident was at the facility, showed:General information: Listen to the resident's perceptions of illness with understanding and empathy; Engage the resident and the resident's family in a discussion about expectations and goals for the resident's health. Review of the social service notes, showed:-On 8/1/25 at 1:08 P.M., Discharge planning narrative note; Concerns for resident falling due to water, a grape, and a smashed cracker on the floor; -On 8/1/25 at 2:32 P.M., Discharge planning narrative note; Concerns from resident's family member; Concerns for resident falling due to water on the floor, a grape on the floor and a smashed cracker on the floor; The resident waited in a brief for a long time and got up to change the brief by him/herself and ended up falling; The resident is not getting pain medications and the resident's mind is fluctuating; Concerns that staff did not follow up on the resident's recent fall; Concerns that staff are going to take it out on the resident because staff is upset that the resident's family member spoke up; The resident's family member said staff do not speak with him/her and no one greets him/her after the family member spoke up about his/her concerns; The family member doesn't want to get anyone in trouble and feels reluctant to report issues; The resident said he/she has been in bed for days and that he/she asked to get up and walk, and the nursing staff told the resident, No. There was a sarcastic jab made when the staff was placing the sign in the resident's room about falling; Staff threw crumbs away but it was actually a pill and a half of pain medication; The resident said he/she never saw a doctor and never got an x-ray when he/she fell. During an interview on 9/3/25 at 10:30 A.M., Social Worker (SW) B said the resident's family member voiced his/her concerns to him/her related to the resident's nursing care. SW B copied and pasted his/her entire note, dated 8/1/25, onto a Word document, printed it off and handed it to Nurse Manager (NM) A. SW B said he/she did not complete an official grievance form. He/She expected NM A to follow up with the resident's issues since they were all nursing care related. SW B did not know who the Grievance Official was for the facility. During interviews on 9/3/25 at 10:45 A.M. and 2:30 P.M., NM A said he/she wasn't sure if a list was provided to him/her by SW B. NM A could not locate the list in his/her office or on e-mail. The only concern that NM A was aware of was the resident's family member requested an x-ray after the resident's fall. NM A did not fill out a grievance form or address any other concerns besides the fall that were located in SW B's notes. NM A said he/she frequently had conversations with the resident and the resident's family member and verbally communicated to the resident and the resident's family member with any resolutions. All complaints and grievances should be addressed immediately if possible. NM A is familiar with the grievance form and said the Grievance Officer was the Administrator. During an interview on 9/4/25 at 11:33 A.M., Family Member C said he/she met with SW B and informed SW B of all the complaints he/she had about Resident #9's nursing care. SW B asked FM C if he/she would like to file an official complaint and FM C said, Yes. FM C said he/she (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	never heard back from the facility about his/her complaints. FM C said he/she never spoke to NM A or anyone from the facility management team. FM C said he/she visited Resident #9 daily at the facility. When FM C was visiting Resident #9, he/she would also inform the nursing staff of nursing care issues but felt as though staff lacked empathy and attentiveness related to FM C's concerns. During interviews on 9/3/25 at 1:50 P.M. and 2:55 P.M., the Clinical Services Director said SW B is new to the facility and SW B had reached out to another Social Worker for direction related to Resident #9's family member's complaints. The family member's complaints were not placed on a formal grievance form. The resolution to the complaints relies on the form. Department heads are notified of grievances, and the Administrator, who is the Grievance Officer, is responsible to follow up with a resolution. She would expect staff to follow the facility grievance policy and its steps. 2585284

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to assure the resident's Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff) accurately reflected the resident's status for one of three residents investigated for hospice (Resident #147). The facility identified 19 residents on hospice. The census was 145 with 126 in certified beds. Review of Resident #147's medical record, showed diagnoses included dementia, Chronic Obstructive Pulmonary Disease (COPD, lung disease), depression, anxiety, and malnutrition;-An electronic physician order sheet (ePOS) showed an order dated [DATE], for a Hospice consult;-A hospice election form showed hospice services began [DATE]. Review of the resident's significant change MDS, dated [DATE], showed:-Assessment Reference Date (ARD) [DATE];-Special services received while a resident: Hospice Care not marked;-Does the resident have a condition or chronic disease that may result in life expectancy less than six months: No. Review of the resident's medical record, showed he/she expired at the facility on [DATE]. During an interview on [DATE] at approximately 2:00 P.M., with the Administrator and the Director of Nursing (DON), the DON said she did not do the MDS assessment but she would have expected for the resident's MDS to have been coded accurately and to accurately reflect the resident's status. The resident's MDS should have reflected he/she had a prognosis for a life expectancy of less than six months and that he/she received hospice care.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure two dependent residents received Activities of Daily Living (ADL) care (Residents #2 and #8). The sample was 25. The census was 145 with 126 in certified beds.Review of the facility's ADL care policy, dated October 2022, showed:-Purpose: To provide grooming and hygiene for each resident, assisting with bathing, dressing and elimination as needed;-Policy: It shall be the policy of the facility that each resident receives assistance with ADLs as needed throughout each day. Consideration will be given to making the experience as home-like and individual as possible;-Procedure: Give nail care as needed. Assist each resident with grooming. 1. Review of Resident #2's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 7/1/25, showed:-Diagnoses included anxiety and heart failure;-Cognitively intact;-Substantial/maximal assistance required for shower/bath;-Supervision or touch assistance required for personal hygiene. Review on 7/21/25, of the resident's July 2025 shower sheets, showed:-On 7/14/25 the resident received a bed bath;-No other shower sheets for July were provided. Review of the resident's care plan, in use at the time of the survey, showed:-Resident needs assistance with activities of daily living (ADL) care but can do some of his/her own with set up assistance;-Resident requires maximum assistance for dressing, grooming/hygiene. Observation on 7/17/25 at 10:30 A.M., showed the resident awake in his/her room and watching TV. The resident's nails appeared long and had dark matter under them. Observation and interview on 7/21/25 at 9:57 A.M., showed the resident's nails to be long with dark matter under them. The resident's left and right feet both had dry peeling skin on the soles and tops of the feet. The resident said staff had not cleaned or treated his/her feet recently. Observation on 7/22/25 at 12:47 P.M., showed the resident's nails to be long with matter under them. The resident's left and right feet both had dry peeling skin on the soles and tops of the feet. 2. Review of Resident #8's quarterly MDS, dated [DATE], showed:-Diagnoses included major depressive disorder, schizophrenia (serious mental illness that affects how a person thinks, feels, and behaves), and epilepsy (seizure disorder);-Moderately impaired cognition;-Dependent for shower/bathe;-Substantial/maximal assistance required for personal hygiene. Review on 7/21/25, of the resident's July 2025 shower sheets, showed:-On 7/18/25, the resident received a bed bath and his/her hair was washed;-On 7/11/25, the resident refused a bath or shower. Review of the resident's care plan, in use at the time of the survey, showed:-Goal: Resident has a goal of maintaining my independence and have his/her needs met to his/her satisfaction with assistance;-Interventions: Resident requires extensive two-person assistance with transfers using a Hoyer lift (full body mechanical lift).-Resident requires extensive two-person assistance with dressing, toileting, grooming, bathing, and bed mobility. Observation and interview on 7/17/25 at 11:35 A.M., showed the resident in his/her bed awake. The resident's nails appeared long and jagged with dark matter under them. The resident's hair was oily and stringy. The resident had a patch of chin hair. He/She said he/she would like staff to assist him/her with cleaning his/her hands, washing his/her hair, and getting rid of the chin hair. Observation on 7/18/25 at 11:54 A.M., showed the resident in his/her room in bed. The resident's hands appeared dirty with matter on them and the resident's nails were dirty with matter under them. The resident had a patch of chin hair. Observation on 7/21/25 at 10:40 A.M., showed the resident awake in his/her bed after finishing breakfast. The resident's hands appeared dirty with food debris. The resident's nails had matter under them. Observation on 7/22/25 at 8:38 A.M., showed the resident awake in his/her bed after finishing breakfast. The resident's hands appeared dirty with food debris. The resident's nails had matter under them. At 12:49 P.M., the resident sat in his/her bed and ate his/her lunch with his/her hands. The resident's hands still had the dried food matter from his/her breakfast. 3. During an interview on 7/23/25 at 8:18 A.M., Licensed Practical Nurse (LPN) C said staff should wash resident's hands before and after meals. Certified Nursing Assistants (CNAs) (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should ensure residents are receiving nail care during showers. If a resident refuses care that should be documented on the shower sheet and the nurse should be informed so that staff can ask the resident again at a later time. Moisture lotion is used for Resident #2's feet. Residents should receive treatments even if they refuse a shower or bath. Nurses should inform the Director of Nursing (DON) if treatments are not working on dry skin. 4. During an interview on 7/23/25 at 8:40 A.M., the DON and Administrator said staff should ensure residents' hands are clean after they eat meals. They would expect nail care to be provided to residents as needed or during showers/baths. They would expect nursing staff to be asking residents if they want their facial hair shaved. They would expect staff to be using moisture lotion on residents if they have dry skin and to inform the DON if the treatment is not working.