

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265732	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER Bentleys Extended Care		STREET ADDRESS, CITY, STATE, ZIP CODE 3060 Ashby Road Overland, MO 63114	

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure each resident fall was thoroughly investigated/evaluated to determine the cause of the fall and failed to implement new interventions and/or modify existing interventions to prevent future falls or reduce the potential of injury or serious injury from future falls. In addition, the facility failed to ensure residents' care plans were updated to reflect current fall interventions and failed to have an updated system in place to communicate fall interventions to staff. Three residents with a history of falls were sampled and problems were identified with all three. (Residents #3, #9 and #7). The census was 57. Review of the facility Assessing Falls and Their Causes policy, undated, showed:-Purpose: The purposes of this procedure are to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall;-Preparation: 1. Review the resident's care plan to assess for any special needs of the resident; 2. Identify the resident's current medication and active medical condition; 3. Assemble the equipment and supplies as needed;-General Guidelines: 1. Falls are a leading cause of morbidity and mortality among the elderly in nursing homes; 2. Approximately 50% of residents fall annually and 10% of these falls result in serious injury; 3. Fear of falling may limit an individual's participation in activities; 4. Falling may be related to underlying clinical conditions and functional decline, medication side effects, and/or environmental risk factors; 5. Residents must be assessed in a timely manner for potential causes of falls;6. Relevant environmental issues should be addressed promptly;-After a Fall (included):c. Once an assessment rules out significant injury, nursing staff will help the resident to a comfortable sitting, lying, or standing position, and then document relevant details.1. Review of Resident #3's quarterly Minimum data Set (MDS), a federally mandated assessment instrument completed by facility staff dated 5/21/25, and located in the electronic medical record (EMR), showed:-Makes Self Understood: Rarely/never understood;-Ability To Understand Others: Rarely/never understands;-Short-term Memory: Memory problem;-Long-term Memory: Memory problem;-Cognitive Skills for Daily Decision Making: Severely impaired-never/rarely made decisions;-Functional Abilities: Independent-Resident completes the activity by themselves with no assistance from a helper: Roll left and right, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, walk 10, 50 and 100 feet;-Diagnoses: Alzheimer's Disease, Non-Alzheimer's Disease (dementia), anxiety and psychotic disorder;-Any Falls Since Admission/Entry or Reentry or Prior Assessment: Yes;-Number of Falls Since Admission/Entry or Reentry or Prior Assessment: Two falls with no injury. Review of the resident's care plan, located in the EMR, showed:-Focus (no date): Communication problem related to poor cognition due to advanced dementia. Goals: The resident will have needs met with staff assistance daily. Interventions (no dates): Anticipate and meet needs;-Focus (no date): Impaired cognitive function/dementia or impaired thought processes related to dementia. Goals: Staff will identify and anticipate needs in effort to show cognitive function decline. Interventions (no dates): Communicate with resident/family/caregivers regarding residents' capabilities and needs. Provide the resident with necessary assistance, stop and return if agitated;-Focus (no date): High risk for falls related to confusion. Unaware of safety needs. Goals: Will not sustain serious injury. Interventions (no dates): Low air loss mattress with raised sides to help resident identify edges of bed. Anticipate and meet resident's needs. Educate resident/family/caregivers about safety reminders and what to do if a fall occurs. The resident needs a Broda chair (mobile recliner) for comfort to reduce restlessness. Utilize a low bed to lower risk of fall and serious injury. Review of the facility Incidents by Incident Type report dated 7/1/25 through 12/10/25, showed: 7/4/25 at 8:30 P.M., received phone call from resident's roommate that resident fell and was on the floor. Went to resident's room and resident was laying on his/her side on the floor next to his/her bed. Review of the resident's progress note's, located in the EMR, showed:-7/4/25 at 9:23 P.M.: Nurse made aware the resident was on the floor. When staff arrived in resident's room, resident was found on side of bed. Resident was wrapped in blanket and blood was noted on the floor and on the resident's person. Hematoma (a localized collection of blood outside of blood vessels, often caused by trauma or injury) noted to left side of face and above his/her brow. Laceration noted to top of scalp with active bleeding. Order to send resident to hospital;-7/8/25 at 3:45 P.M.: At 1:30 P.M., called to shower room by staff who stated resident was walking through doorway and tripped over his/her own feet and before staff could reach resident, he/she fell to the floor on his/her right side. No injuries noted. Review of the resident's Fall Risk Evaluation dated 7/8/25, and located in the EMR showed resident is at risk to fall. Review of the resident's progress note dated 7/15/25</p>		