STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265732	A. Building B. Wing	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bentleys Extended Care	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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observation, interview, and record review, the facility failed to ensure one resident (Resident #2) was free from physical abuse when Certified Nurse Aide (CNA) C covered and twisted the resident's mouth when he/she cried during a shower, which resulted in bruising to the resident's face. The sample was 3. The census was 49.Review of the facility's Abuse Prevention Program policy, undated, showed:-Policy Statement: Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual, or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms;-Policy Interpretation and Implementation:-As part of the resident abuse prevention, the administration will:--Require staff training/orientation programs that include such topics as abuse prevention, identification and reporting of abuse, stress management, and handling verbally or physically aggressive resident behavior;-Establish and implement a Quality Assurance and Performance Improvement (QAPI) review and analysis of abuse incidents; and implement changes to prevent future occurrences of abuse. Review of the facility's Abuse Investigating and Reporting policy, undated, showed:-Policy Statement: All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source shall be promptly reported to local, state, and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported;-Role of the Administrator: The Administrator will keep the resident and his/her representative (sponsor) informed of the progress of the investigation;-Role of the Investigator:--The investigator will notify the ombudsman that an abuse investigation is being conducted. The ombudsman will be invited to participate in the review process;-Reporting:--All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following persons or agencies;---The local/State ombudsman;---Law enforcement officials;---The facility Medical Director;--The resident and/or representative will be notified of the outcome immediately upon conclusion of the investigation. Review of Resident #2's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/31/26, showed:-Moderate cognitive impairment;-Felt down, depressed, or hopeless half or more of the days;-No behaviors exhibited;-Upper and lower extremity impairment on one side;-Dependent on assistance for bathing;-Diagnoses included depression, high blood pressure, stroke, and hemiplegia (paralysis to one side) or hemiparesis (weakness to one side). Review of the resident's care plan, in use at the time of survey, showed:-Focus: The resident had impaired cognitive function or impaired thought processes related to memory loss;--Interventions included cue, reorient and supervise as needed;-Focus: The resident was/had the potential to be physically and verbally aggressive related to anger, depression, history of attempting to harm others, poor impulse control, and throwing objects;--Interventions included:---Communication: Provide physical and verbal cues to alleviate anxiety, give positive feedback, assist verbalization of source of agitation, assist to set goals for more pleasant behavior, (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 0600 Level of Harm - Actual harm Residents Affected - Few	and encourage seeking out of staff member when agitated;---When the resident becomes agitated, intervene before agitation escalates, guide away from source of distress, engage calmly in conversation. If response is aggressive, staff to walk calmly away, and approach later.----Staff responsible for interventions included nursing staff;-Focus: The resident had a mood/behavior problem related to depression, ineffective coping behaviors. The resident had yelling behaviors, negative verbalizations, frequent complaints/expresses dissatisfaction, and depressed mood;--Interventions included monitor, record, and report to medical physician as needed mood patterns signs and symptoms of depression, anxiety, sad mood, as per facility behavior monitoring protocols;-Focus: The resident had depression related to current health status;--Interventions included monitor, document, report as needed any signs and/or symptoms of depression, including hopelessness, anxiety, verbalizing negative statements, repetitive anxious or health-related complaints, and tearfulness. Review of the resident's progress notes showed:-On 5/11/26 at 4:00 P.M., the Director of Nurses (DON) documented the resident reported to this DON that a CNA had put their hand over his/her mouth because he/she was crying. The CNA had already left facility prior to resident's report. The resident was alert and oriented times three (oriented to person, place and time);-On 5/12/26 at 3:30 P.M., staff documented an incident follow up for the reported incident. Light purplish discoloration noted to right side of mouth. The resident denied pain. Review of the facility's investigation showed:-An Incident Investigation Report, undated, showed:--Date and time of incident: 5/11/26, between 7:00 A.M. and 11:30 A.M.;--Location: Shower room;--Incident description: The resident alleged he/she was in the shower room and CNA D put his/her hand over the resident's mouth and twisted the resident's mouth because he/she was crying;---Individuals involved: The resident and CNA C (alleged perpetrator);---Witnesses: None to the incident. CNA B was in the shower room for a period of time while resident and CNA C were in there. Statement attached;--Evidence collected: The resident had a bruise to right side of mouth. Photos taken of bruise on 5/12/26 and 5/14/26;--Conclusion: After reviewing statement and the physical findings, the resident's allegations appear to be substantiated;-A typed statement from the resident, undated, showed the resident said CNA C grabbed his/her mouth. The resident had bruises. CNA C said the resident could cry all he/she wanted, then grabbed the resident's mouth and twisted it;-A handwritten statement from CNA B, dated 5/14/26, in which CNA B documented he/she walked in the shower room and heard someone crying. He/She observed the resident getting his/her shower done and CNA C gave the shower. When CNA B asked the resident why he/she was crying, the resident said, I just want to die, about three times. CNA B left the shower room;-Two photographs of the resident, undated, showed a purple bruise, approximately one inch long, to the right side of the resident's mouth. Observation on 5/19/26 at 9:01 A.M., showed the resident with yellow, black, and blue bruises to the right side of his/her mouth and chin. He/She had bruising around his/her left eye socket. During an interview, the resident said the bruising around his/her eye was from when he/she fell out of bed a couple weeks ago. The bruising by his/her mouth was from CNA C grabbing and pinching his/her mouth last week while the resident received a shower. CNA C did this because the resident was crying. There was no one else in the shower room when this occurred. The resident said his/her mouth hurts. During an interview on 5/20/26 at 10:31 A.M., CNA C said he/she provided a shower to the resident on the morning 5/11/26. During the shower, the resident cried and repeated he/she wanted to die, which was the resident's normal behavior when he/she doesn't want to do something. When this happens, CNA C tells the resident if he/she keeps crying, it was going to take longer. CNA C tried to wipe the resident's face and mouth, and the resident tried to grab and squeeze CNA C's hand. CNA C denied squeezing, pinching, or twisting the resident's mouth. He/She had no idea how the resident got bruising to his/her mouth. The resident did not have any bruising on his/her face during the shower provided by CNA C. CNA C had never been instructed on how to handle the resident's behaviors by walking away, asking for assistance, or reporting it to the nurse. CNA B was on the other side of the curtain in the shower room when CNA C showered the resident. CNA B asked who CNA C was showering because (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	he/she heard the resident crying, and CNA B pulled back the curtain so he/she could see. CNA B did not assist with the shower. During an interview on 5/20/26 at 11:50 A.M., CNA B said on 5/11/26, he/she entered the shower room to get supplies and heard a resident crying and saying he/she wanted to die. CNA B checked to see who it was, and saw it was the resident. This was normal behavior for the resident. CNA C was finishing up the resident's shower and was drying and dressing the resident. CNA B asked CNA C why the resident was crying, and the resident said because he/she didn't like taking the shower. CNA B only saw the resident crying and the CNA getting the resident dried off and dressed. CNA B denied being educated on specific behaviors and how to handle the resident. The resident was alert and knows what's going on. He/She just liked to cry when he/she didn't like something. A new bruise around the resident's mouth showed up last week, a day or so after the shower incident. During an interview on 5/20/26 at 11:03 A.M., the resident's Power of Attorney (POA) aid the resident was cognitive and knew what was going on around him/her. The facility notified the POA of an abuse allegation. He/She was unaware of the bruise to the resident's mouth from the alleged abuse and had not received any updated reports since he/she was notified of the incident. He/She was unaware of the outcome of the facility's investigation. During an interview on 5/20/26 at 12:37 P.M., the DON said it was not appropriate for staff to continue performing care against a resident's expressed wishes, including crying. It was never appropriate for staff to cover a resident's mouth. The resident always cried when he/she did not like what was going on. When CNA B saw the resident was upset during the shower on 5/11/26, the DON expected CNA B to have notified the nurse about the resident being upset. Staff should follow the resident's care plan when caring for the resident's behaviors. Staff should also adhere to the facility's abuse and neglect policies. The facility conducted an investigation, which concluded that abuse occurred. The resident was consistent in reporting what happened when asked several times, and he/she was able to demonstrate how CNA C covered and twisted his/her mouth, which lined up with the bruising observed by the resident's mouth. The bruising showed up the next day, after the incident. The facility's abuse and neglect policy and procedures should be followed. During an interview on 5/19/26 at 8:36 A.M., CNA C said he/she was not aware of an abuse allegation involving the resident. The resident was alert and knows what was going on. He/She had behaviors and cried if he/she did not like what was going on. He/She required two staff to assist with care. During an interview on 5/19/26 at 1:47 P.M. Administrator said CNA C was told to leave the facility prior to the alleged abuse reported by resident #2 due to CNA C having a verbal confrontation with the DON about scheduling. After CNA C had been told to leave, the resident reported the alleged abuse. CNA C was terminated for the verbal altercation with the DON and the abuse to the resident. During an interview on 5/20/26 at 1:08 P.M., the Administrator said the resident had behaviors and was known to cry when he/she didn't want to do something or didn't like something. When the resident cries during a shower, CNAs should complete the resident's shower and let the nurse know about the crying incident. It was never appropriate for staff to put their hands over a resident's mouth for any reason. CNA B should have assisted CNA C when he/she saw the resident crying and/or at least let the nurse know about the incident. All residents should be free from abuse and facility staff should follow the facility's policies and procedures for abuse. She reviewed the investigation findings and confirmed that abuse occurred. She expected staff to follow the facility's policy and procedures for abuse. 3014047