

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265757	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER Bentwood Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 1501 Charbonier Road Florissant, MO 63031	

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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46967</p> <p>Based on observation, interview and record review, the facility failed to follow their policy by failing to ensure residents received care consistent with professional standards. Staff failed to follow physician orders and perform wound treatments for two of three residents sampled (Residents #9 and #12). The census was 106.</p> <p>Review of the facility's Wound Management policy, last reviewed on 11/15/22, showed:</p> <ul style="list-style-type: none"> -Policy: To promote wound healing of various types of wounds, the facility will provide evidence-based treatments in accordance with current standards of practice and physician orders; -Procedure: Wound treatment will be provided in accordance with physician's orders; -Cleansing method; -Type of dressing; -Frequency of dressing change; -Charge Nurse will notify physician in the absence of treatment orders; -Wound dressings will be applied in accordance with manufacturer's recommendations; -Wound Characteristics/Documentation: <ul style="list-style-type: none"> -Location of the wound; -Size (shape, depth, tunneling and/or undermining), volume and drainage characteristics; -Pain evaluation; -Condition of the wound bed; -Condition of the peri-wound (skin surrounding the wound); -Guidelines for Dressing Selection: <p>(continued on next page)</p>

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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Obtain physician's order;</p> <p>-Treatments will be documented on the Treatment Administration Record (TAR);</p> <p>-The effectiveness of the treatments will be monitored through ongoing evaluation of the wounds.</p> <p>Review of the facility's Physician Orders policy, last reviewed on 9/28/22, showed:</p> <p>-Policy: To provide guidance and ensure physician orders are transcribed and implemented in accordance with professional standards, state, and federal guidelines;</p> <p>-Responsibility: Licensed nursing, administration, and Director of Nursing (DON);</p> <p>-Procedure: Physician orders must be recorded in the medical record by the Licensed Nurse authorized to transcribe such orders. Physician orders must be documented clearly in the medical record. Physician orders must be documented clearly in the medical record. Physician orders will be transcribed to the appropriate administration record electronic Medication Administration Record (MAR/eMAR) or electronic Treatment Administration Record (TAR/eTAR).</p> <p>1. Review of Resident #9's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 8/20/24, showed:</p> <p>-Diagnoses included cancer, high blood pressure, peripheral vascular disease (lack of blood flow to the legs), diabetes, high cholesterol and end stage renal disease;</p> <p>-Cognitively intact;</p> <p>-No documented wounds.</p> <p>Review of the resident's care plan, in use at the time of survey, showed it did not address the resident's treatment to his/her right, first toe.</p> <p>Review of the resident's physician orders (POs), dated September 2024, showed an order dated 9/20/24, at 7:00 A.M., right first toe, cleanse with wound cleanser, apply betadine (a topical antiseptic that treats minor wounds and prevents infections), cover with gauze and wrap with kerlix (gauze) every day shift (7:00 A.M. -3:00 P.M.).</p> <p>Review of the resident's eTAR, dated September 2024, showed:</p> <p>-On 9/20/24, the treatment was documented as completed;</p> <p>-On 9/21/24, the treatment record was blank;</p> <p>-On 9/22/24, the treatment was documented as completed;</p> <p>-On 9/23/24, the treatment was documented as completed;</p> <p>-On 9/24/24, the treatment was documented as resident out of facility.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation and interview on 9/24/24 at 10:46 A.M., showed the resident lay in bed. The resident said the dressing on his/her right big toe were not completed every day. The resident had a dressing on his/her right first toe, dated 9/20/24.</p> <p>Observation and interview on 9/25/24 at 8:58 A.M., showed the resident sat in his/her wheelchair, at the nurse's station. The resident had a dressing on his/her right, first toe, dated 9/24/24. The resident said a nurse changed the dressing last night.</p> <p>During an interview on 9/25/24 at 10:57 A.M., Licensed Practical Nurse (LPN) G said the resident's wound is supposed to be cleansed daily, between 7:00 A.M. and 3:00 P.M. If the treatment gets missed, staff will do it later. If the treatment is done late, it will appear as yellow or red on the eTAR. If the TAR is blank, it means the treatment was not completed. He/She made a mistake on 9/23/24. He/She usually predates the tape and must have put the wrong date on the dressing. On 9/24/24, the resident was not in the facility at the end of his/her shift. He/She left instructions for the evening shift nurse to change the resident's dressing. The nurse did not document the treatment. He/She was assigned multiple duties and could not complete the treatment before the resident left the facility for dialysis.</p> <p>During an interview on 9/25/24 at 11:13 A.M., LPN H said when he/she completes the resident's treatment, he/she puts betadine and gauze on the resident's toe. He/She dates and initials the dressing. He/She was not sure why the resident's dressing said 9/20/24. He/She changed the dressing on 9/22/24. He/She must have grabbed the tape with the wrong date on it. He/She was probably moving too fast. If the TAR is blank, the treatment was not completed. The resident usually leaves for dialysis at 9:00 A.M. on the weekend. He/She is assigned multiple duties and cannot complete the resident's treatment before he/she leaves.</p> <p>2. Review of Resident #11's significant change MDS dated [DATE], showed:</p> <ul style="list-style-type: none"> -admitted [DATE]; -Severe cognitive impairment; -Diagnoses included diabetes, adult failure to thrive, dementia, and pressure ulcer of sacral region; -Stage four pressure ulcer (Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining or tunneling) present upon admission. <p>Review of the resident's care plan, in use at the time of survey, showed:</p> <ul style="list-style-type: none"> -Focus: The resident had potential/actual impairment to skin integrity of the sacrum, moisture associated skin damage (MASD), related to fragile skin, and infection to right buttock; -Goal: The resident will have no complications related to MASD infection of the sacrum/right buttock through the review date; <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Interventions: Perform treatment to wound per current treatment order. Assess wound for signs and symptoms of infection with each dressing change/treatment. Report positive findings of redness, warmth, swelling, increased drainage, and increased pain.</p> <p>Review of the resident's POs, dated September 2024, showed an order dated 9/19/24 for sacrum, cleanse area with wound cleaner, apply Dakin's (a liquid antiseptic that is used to treat wounds) moistened gauze, followed by dry gauze and cover with border gauze every day shift (7:00 A.M.-3:00 P.M.).</p> <p>Review of the resident's TAR, dated September 2024, showed on 9/19/24 through 9/23/24, the treatment was documented as completed.</p> <p>Observation and interview on 9/24/24 at 11:00 A.M. and 11:32 A.M. , showed LPN G entered the resident's room with the hospice nurse. The bedside table was set up with wound care supplies and the resident was lying on his/her left side with assistance from the hospice nurse. LPN G said the resident had a wound to the sacral area. Observation showed no old dressing on the wound. LPN G said it was removed during peri care by a Certified Nurse Assistant (CNA) earlier. LPN G sanitized and applied gloves, cleansed the wound with wound cleaner, removed his/her gloves, hand sanitized, applied new gloves, applied prepared Dakin's-soaked gauze to wound, covered with 4 x 4 gauze, covered with abdominal dressing, covered with Medi-port tape, an applied date on the dressing. This surveyor noticed a trash can next to the resident bed, with only an old dressing lying in the bottom. Surveyor requested LPN G remove the dressing from the trash can. LPN G removed the dressing and observation showed the dressing was still warm, smelled foul, was saturated, and dated 9/20/24. LPN G said he/she assumed this was the dressing removed today since it was still warm, it was the only thing in the trash can, and verified the date on the dressing is the date he/she applied it, on 9/20/24. LPN G said staff must have put it in the trash when it fell off during peri-care. The hospice nurse said the old wound dressing was not removed while she was in the room. LPN G said if there is a blank on the TAR, that means the treatment was not completed. A check mark and initials mean treatment was completed and the initials are the initials of the nurse completing the treatment. He/She has never marked and initialed a treatment completed if she has not completed it. He/She waits until completion of treatment before marking completed. He/She only marks a date on a new dressing, no time, or initials.</p> <p>During an interview on 9/25/24, at 11:50 A.M., the Assistant DON said he/she dates dressing changes after they are completed. He/She must have marked the wrong date on the dressing or used pre-cut and dated tape kept in treatment cart to secure the dressing by mistake. He/She only marks the date on new dressings, no time, or initials.</p> <p>3. During an interview on 9/25/24, at 11:30 A.M. the Administrator and Regional Nurse said they do not expect staff to mark a treatment as completed if it has not been completed. Staff should follow facility policy and procedure and use best practice method.</p> <p>MO00242127</p>		

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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate foot care.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42795</p> <p>Based on observation, interview and record review, the facility failed to ensure that one resident (Resident #1) received proper treatment and care to maintain mobility and good foot health. The sample was four. The census was 106.</p> <p>Review of the facility's Activities of Daily Living (ADL) policy, reviewed 7/21/22, showed:</p> <ul style="list-style-type: none"> -Policy: Nursing staff will assist in bathing resident to promote cleanliness and dignity; The charge nurse will be made aware of residents who refuse bathing. -Bed Bath: Wash feet and in between toes. <p>Review of the facility's Podiatry (foot) Services policy, reviewed 10/7/21, showed:</p> <ul style="list-style-type: none"> -To provide podiatry services to the residents as needed; -Responsibility: Licensed Nurse; -Procedure: <ul style="list-style-type: none"> -Determine when the podiatrist will be in the facility; -The charge nurse will prepare a list of residents who require podiatry services; -Communication to the attending physician will be done by the licensed nursing staff of any recommended treatment made by the podiatrist (foot physician); -Approval must be obtained from the resident's attending physician for any treatment change before implementation by nursing staff; -The Administrator will engage the services of a podiatrist. <p>Review of Resident #1's face sheet, undated, showed diagnoses that included peripheral vascular disease (PVD, a narrowing of blood vessels that constricts blood flow to the legs), difficulty walking, kidney failure, hepatitis (inflammation of the liver), muscle wasting, abnormalities of gait and mobility, polyarthritis (arthritis that affects five or more joints at a time).</p> <p>Review of the resident's 5-day scheduled Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 8/19/24, showed:</p> <ul style="list-style-type: none"> -Dependent on staff for showering and bathing, lower body dressing, and to put on and take off footwear. <p>Review of the resident's annual MDS, dated [DATE], showed:</p> <p>(continued on next page)</p>		

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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Skin Monitoring: Comprehensive Certified Nursing Assistant (CNA) Shower review showed:</p> <p>-On 9/3/24, the resident had dryness, a circle was on the diagram of a body on the lower extremities and feet labeled dry; Lotion applied to both legs and feet;</p> <p>-On 9/6, 9/10, and 9/13/24 the resident refused bathing.</p> <p>Review of the resident's progress notes, dated 9/13/24 at 10:34 A.M., showed the resident was sent to the hospital for an evaluation.</p> <p>Review of the resident's hospital photographs, dated 9/13/24 at 12:48 P.M., labeled right top foot, showed the resident's foot was extremely dry. The resident's right top foot had large white flakes and deep crevices in the skin. His/Her toenails were extremely thick and jagged in appearance.</p> <p>Review of the resident's hospital photographs, dated 9/13/24 at 12:47 P.M., labeled right foot, bottom, showed extremely dry skin, the bottom of the resident's entire big toe was covered with thick white, crusted, callus-like skin. The bottom of his/her right foot from the heel to the ball of the foot had scale-like dry skin and crevices in the skin and was leather- like appearance.</p> <p>Review of the resident's hospital photographs, dated 9/13/24 at 12:49 P.M., labeled left foot, upper, showed the entire top of his/her foot had extremely dry skin and scale-like appearance with large white flakes of dry skin peeling off. His/Her toenails were extremely thick and jagged in appearance.</p> <p>Review of the resident's hospital photographs, dated 9/13/24 at 12:47 P.M., labeled left foot, bottom, showed large crevices of dry skin from the resident's heel to the ball of his/her foot. The resident's entire left large toe had layers of thick white, crusted, callus-like skin with large flakes of skin peeling off.</p> <p>During an interview on 9/13/24 at 5:40 P.M., Hospital Nurse A said the resident was wearing fall precautions socks when he/she arrived to the emergency room (ER). The socks were growing into his/her skin. He/She had to soak the resident's feet because the socks were imbedded. Nurse A said it took a half an hour to remove the socks because there was significant thick skin underneath.</p> <p>During an interview on 9/14/24 at 7:20 A.M., Hospital Registered Nurse (RN) B said the resident's feet were crusted with thick white dry skin when he/she arrived to the ER. The socks the resident were wearing were moulded to his/her feet.</p> <p>During an interview on 9/14/24 at 9:35 A.M., Hospital RN D said the resident arrived to the ER, and he/she wore socks which had imbedded skin and were crusted with dry thick flakes of skin.</p> <p>During an interview on 9/14/24 at 9:50 A.M., Hospital RN C said the resident came into the ER with socks on that looked like they had not been changed in a very long time. Both feet were extremely dry, and it was a challenge removing the socks off the resident's feet.</p> <p>(continued on next page)</p>		

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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation and interview on 9/14/24 at approximately 9:50 A.M., showed the resident lay in bed at the hospital. The resident's toenails to both feet were extremely thick and jagged. There was minimal dryness to both feet with no open areas. Hospital RN C said the resident's feet looked better since they have been cleaned and moisturized after admission to the hospital.</p> <p>During an interview on 9/14/24 at approximately 12:00 P.M., Licensed Practical Nurse (LPN) E said the resident always had an unusually large amount of thick dry skin to his/her feet that was always peeling off. The bed sheet would be covered with dry skin that had peeled off. The resident's feet and legs were always extremely dry and his/her toe nails were thick. LPN E did not know if the resident was currently being seen by the podiatrist or if the resident had seen one in the past at the facility. The resident did not refuse care for LPN E. LPN E did not see the resident's feet prior to being sent to the hospital.</p> <p>During an interview on 9/14/24 at 2:15 P.M., Certified Nursing Assistant (CNA) F said he/she had a good rapport with the resident, and the resident would normally allow him/her to bathe him/her. The resident was a bed bath and did not like showers because he/she would get cold. The resident required more assistance with bathing and hygiene needs since the resident returned from the hospital about a month ago. The resident normally always had extremely dry skin to his/her feet and legs. When CNA F would remove the resident's socks and shake them out, there would be an extremely large amount of dry skin in his/her socks. The resident also had thick toenails. CNA F would use Vaseline or A & D ointment (an ointment used to protect skin form irritation and inflammation by creating a protective barrier) to moisturize the resident's feet and legs. CNA F would retrieve the Vaseline or A & D ointment from the Certified Medication Technician (CMT) who had the ointments in his/her cart. CNA F said he/she changed the resident's socks daily.</p> <p>During an interview on 9/16/24 at 9:53 A.M., the Interim Director of Nursing (DON) said she expected staff to reach out to the physician if the resident's dry skin was not getting better, to obtain other treatment orders and a podiatry consult. She expected the nurse to call the doctor and have the triamcinolone cream to include the resident's feet, since he/she had dry skin to his/her feet. The resident was private pay so she wasn't sure if the resident had approved podiatry services, but expected some type of documentation from the Social Worker that podiatry was offered for his/her feet issues. She expected staff to notify the DON or the charge nurse if the treatments were not working for the resident's dry skin issues. The nurses were expected to remove the resident's socks during their weekly skin assessments.</p> <p>During an interview on 9/17/24 at 8:55 A.M., the Administrator said the nursing staff were expected to reach out to the physician if treatment orders need adjustments and follow whatever the doctor recommended. Every resident in the facility was offered podiatry, and it is in their admission packet. She was not able to provide documentation that the resident was approached about podiatry services and that it would require an out-of-pocket expense.</p> <p>MO00242033</p>		