

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  11/17/2025
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)
F 0689  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	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 - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review, the facility failed to ensure one resident, identified as high risk for falls, received adequate supervision to prevent accidents (Resident #1). Staff placed the resident near the nurses' station for close observation in a locked wheelchair. Staff left the area, during which time Resident #1 attempted to get up and fell from the wheelchair, resulting in a fractured wrist. In addition, the facility failed to ensure fall prevention interventions for three residents who were identified as high risk for falls, were consistently and accurately documented across the care plan, physician orders, and progress notes, as required by the facility's Fall Management Policy and Incident Documentation and Investigation Policy (Residents #1, #3 and #4). The sample size was three. The census was 91. Review of the facility's policy entitled, Fall Management, dated 2/28/23, showed:-Policy: is to provide an environment that remains as free of accident hazards as possible. The facility will complete a Morse Fall Scale Evaluation on residents to determine who are at risk for falling and to develop appropriate interventions to provide supervision and assistive devices to prevent to minimize further falls and/or reduce injuries.-Procedure (Risk Identification/Evaluation): Residents shall be evaluated for fall risk upon admission/re-admission, post-fall, quarterly, annually and significant change using Morse Fall Scale Evaluation. Identify risks factors should be address in the resident's care plan to ensure individualized interventions to reduce the risk are implemented. -Steps: Charge nurse will evaluate for injury; complete neurological evaluation post-fall on residents with potential head injury or unwitnessed fall; notify Primary Care Physician (PCP), resident representative; implement interventions to reduce further occurrences; document in resident's medical record Electronic Medical Records (EMR)/ Point Click Care (PCC); complete incident report; implement post-fall evaluation and documentation; the care plan should be reviewed after every fall and updated with a new intervention. Review of the facility's policy entitled, Accident &amp; Incident Documentation &amp; Investigation, dated 4/26/23, showed:-Policy: Accidents and/or Incidents involving residents will be investigated and documented on an Incident Report entry in the EMR.-Procedure: The licensed nurse at the time of the incident is responsible for documenting the incident in the resident's medical record, in accordance with the guidelines below and set forth in the Incident Report; The license nurse may complete a Nurses' note and update the resident care plan as needed; The nurse's notes may contain the following documentation - clear objective facts of what occurred; Incident Report will be completed in the EMR. 1. Review of Resident #1's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 9/16/25, showed: -Diagnoses included hemiplegia following cerebral infarction affecting right dominant side (paralysis on one side of body caused by stroke), unsteadiness on feet, dysphagia-orpharyngeal phase (trouble swallowing during the mouth and throat stage of swallowing); -Severe cognitive impairment;-No behaviors; -Functional abilities showed walker, wheelchair; supervision or touching assistance with toileting and sit to stand; partial to moderate assistance with the ability to wheel at least 150 feet in corridor. Review of the resident's care plan, in use during the survey, showed:-Focus: limited physical mobility;-Goal: will remain free of complications relate to immobility, fall related injury through the next review date;-Interventions: Provide supportive care, assistance with mobility as needed Document as needed. -Focus: Resident has a history of falls and is at risk for further falls with confusion, impaired mobility, incontinence;-Goal: Resident will be free of falls through the review date; -Interventions: Resident to be sitting at nurse's station for direct observation until safety deemed established per nursing discretion; on 10/2/25 fall mat at beside; on 10/6/25 provide activity apron; resident needs activities that minimize the potential for falls while providing diversion and distraction. Bed positioning is not addressed. Review of the Physician Order Sheet (POS), showed an order, dated 10/2/25, for floor mats; no order for low bed. -Progress notes showed:-10/6/25 at 7:20 A.M., Resident up throughout the night, resident at nurse station for observation, resident self-propels in wheelchair, as desires, nurse later observed resident on floor in sitting position, no pain voiced, resident has history of dementia and could not recall event. Noticed swelling to left wrist and hand. X-ray ordered.-10/6/25 at 3:13 P. M., Small hematoma (raised area with skin discoloration and swelling) noted to left forehead and bruising noted around left eye. X-ray results came back, impression stated acute distal radius and ulna fracture (the two forearm bones: the radius and ulna, close to the wrist). Spoke with Nurse Practitioner, received order to send resident to emergency room (ER) for further evaluation;-10/9/25, Interdisciplinary Team (IDT) risk meeting held today, care plan reviewed and interventions in place, resident alert and not acute changes</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>(continued on next page)</p>

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observation, interview and record review, the facility failed to ensure staff followed the facility's policy regarding gastrostomy tube (g-tube, a small rubber tube surgically inserted through the abdomen in to the stomach to administer nutrition, fluids and medications) feedings by not recording on the bag the name of the formula, the date and time hung and the resident's name, failed to accurately determine the amount of food and fluid consumed per meal and also failed to follow physician orders for two residents (Residents #3 and #40) out of three sampled residents. The facility also failed to ensure staff correctly positioned a resident who received tube feedings (Resident #3). The census was 96. Review of the facility's Tube Feeding policy, undated, showed:-Gastric enteral tube feeding involves delivery of a liquid feeding formula directly to the stomach via an enteral tube (providing nutrition directly into the digestive system through a tube);-Verify the practitioner's order;-Position the patient with the head of the bed elevated to at least 30 degrees or upright in a chair to prevent aspiration (accidental inhalation of foreign material, such as food, liquid, or saliva, into the lungs);-Make sure that the enteral formula container is labeled with the patient's identifiers; formula name (and strength if diluted); date and time of formula preparation; date and time the formula was hung; administration route; rate of administration; administration duration (if cycled or intermittent); initials of who prepared, hung, and checked the enteral formula against the order; expiration date and time; dosing weight (if appropriate); and notation ENTERAL USE ONLY. 1. Review of Resident #3's care plan, undated, showed:-Problem: Activities of daily living (ADL) self-care performance deficit. Interventions included: Totally dependent on staff for repositioning and turning, dependent on staff for personal hygiene/oral care. ADL-Eating;-Problem: History of dehydration or potential fluid deficit related to tube feeding. Interventions included: Monitor and document intake and output as per facility policy and as needed for assistance with fluid intake in order to meet daily requirements;-Problem: Nutritional problem or potential nutritional problem. Interventions included: Provide and serve diet as ordered and Nutrition - Amount Eaten. Review of the resident's electronic health medical record (EHMR), showed:-The resident's medical diagnoses included: hemiplegia (paralysis on one side of the body) affecting right dominant side, moderate protein-calorie malnutrition, diabetes mellitus, dysphagia (difficulty swallowing) and gastrostomy (g-tube, a tube surgically inserted into the stomach to provide hydration, nutrition and medications). Review of the resident's Brief Interview for Mental Status (BIMs) evaluation, dated 10/6/25, showed the resident had severe cognitive impairment, with a score of 5 out of 15. Review of the resident's Physician Order Sheet (POS), showed:-An order, dated 10/6/25, for mechanical soft diet, mechanical soft texture, thin consistency, mechanical soft diet for pleasure. Feeding assistance for diet;-An order, dated 10/9/25, for head of bed (HOB) elevated every shift for tube feeding (TF);-An order, dated 10/9/25, for Jevity 1.2 (calorically, dense fiber fortified therapeutic nutrition for long or short term tube feeding) 65 milliliters (ml) an hour (hr), 150 water flushes (water flushes for resident hydration and to prevent g-tube from clogging) every 4 hours. Give TF in the evening;-An order, dated 10/9/25, for Jevity 1.2, give a bolus (single large dose of a substance) of 240 ml if less than 50% of meal consumed, three times a day. Review of the resident's nutritional report, dated 10/10/25, showed:-Assessment: The resident was on a mechanical soft diet, oral intake was 25% with an order for Jevity 1.2, 65 ml/hr, at night from 6:00 P.M. to 6:00 A.M., with an order for 240 ml bolus of Jevity 1.2 if consumed less than 50% of meal;-Goals: Adequate tube feeding and tolerance and greater than 75% intake at meals. Review of the resident's nutrition history, dated 10/14/25, showed:-Diet order: Nothing by mouth (NPO)/pleasure diet mechanical soft;-Assistance was not required. Review of the resident's progress notes, dated 10/16/25, at 2:17 P.M., showed the resident required full assistance with ADLs and the resident received continuous feeding via g-tube site. Review of the resident's ADL documentation for amount eaten, dated 10/5/25 through 10/21/25, showed:-No documentation after 10/16/25 showing the percentage of the meal the resident consumed. Review of the resident's ADL documentation for fluid, dated 10/5/25 through 10/21/25, showed:-No documentation after 10/16/25 showing the amount of fluid the resident consumed. Review of the resident's discharge evaluation progress note, dated 10/17/25 at 2:54 P.M., showed:-Reason for evaluation was discharge;-Self Care evaluation dates for 3-day window: 10/15/25 through 10/17/25 with collaboration from Licensed Nurse and MDS Nurse;-Eating: Discharge performance: Dependent. Observation on 10/21/25 at 8:44 A.M., showed the resident lay in his/her bed, asleep, with a feeding pump at bedside, not connected to the resident and not running. The resident's bedside table was pushed against the wall on the right side of the resident's bed with several absorbent pads stacked in a pile and a pink cup</p>		