STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265757	A. Building B. Wing	06/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bentwood Nursing & Rehab	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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview and record review, the facility failed to ensure services were provided to treat pressure ulcers (skin and tissue damage caused by prolonged, unrelieved pressure on the skin) and/or wounds for one resident (Resident #2). On 06/05/26, a nurse identified a Stage II (a partial-thickness skin loss that damages the outer epidermis and dermis) pressure ulcer on the resident's right buttock but failed to obtain treatment orders until 06/18/26, after the resident had a fall and a full skin assessment was completed. The sample was 5. The census was 105. Review of the facility's Wound Management Policy, revised 11/15/22, showed:-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 Management: --Wound treatment will be provided in accordance with physician's order; --Charge Nurse will notify physician in the absence of treatment orders;--Treatment selection will be based on the etiology of the wound;--Pressure injuries will be differentiated from non-pressure wounds. -Wound Characteristics/Documentation: --Location of the wound; --Pressure injury & stage; --Non-Pressure level of tissue destruction; --Size (shape, depth, tunneling and/or undermining); --Volume & exudate (drainage) characteristics; --Pain evaluation; --Presence of infection/bioburden; --Condition of the wound bed & wound edges; --Condition of the peri-wound (skin surrounding the wound);-Guidelines for Dressing Selection: Obtain physician's order. Treatments will be documented on the Treatment Administration Record (TAR).-The effectiveness of treatments will be monitored through ongoing evaluation of the wound(s). Review of Resident #2's medical record, showed:-admission date 05/09/26;-Diagnoses included altered mental status, end stage renal disease (ESRD, kidney disease), diabetes, depression, and muscle weakness. Review of the resident's care plan, revised 05/27/26, showed:-Focus: Resident has a potential/actual impairment to skin integrity related to fragile skin;-Goal: The resident will maintain or develop clean and intact skin by the review date;-Interventions: Pressure reducing mattress while in bed. Review of the resident's skin assessment, dated 06/05/26 at 6:27 P.M., showed:-Site: Right buttock;-Type: Pressure;-Length: 3.0 centimeter (cm);-Width: 2.0 cm;-Depth: Blank;-Stage: II. Review of the resident's electronic physician order sheet (ePOS) and TAR for June 2026, showed:-An order, start date 06/05/26 and end date 06/05/26, for STAT (immediately) due to pain: Wound consult as needed to evaluate and treat right buttocks open wound, appears to be a Stage II;--Marked as completed on the TAR on 06/08/26 at 9:41 A.M. Review of the resident's skin assessment, dated 06/18/26 at 10:34 A.M., showed no new skin issues noted. Review of the resident's wound assessment, dated 06/18/26 at 10:58 A.M., showed:-Date wound identified: 06/18/26;-Where was wound acquired: Acquired after admission to the facility;-Type of Wound (pressure or non-pressure): Blank;-Wound description: Right gluteal fold. Type: Skin tear. Length 2.7 cm, width 2.8 cm, depth 0.1 cm. Stage N/A;-Drainage: Serosanguinous (thin, watery, pale pink or light red fluid);-Resident exhibits two or more conditions that increase likelihood of the development of an unavoidable wound: No;-Resident demonstrates signs/symptoms that increase the likelihood of the development of an unavoidable: No;-Are treatment/equipment in place: Yes;-Treatments: Turning and repositioning, wound treatment/application of dressing;-Is pain associated with the wound: No;-Physician Notified: Yes. Review of the resident's progress note, dated (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	06/18/26 at 11:12 A.M., showed new skin tear/open wound noted to right gluteal region. Skin flap present with drainage noted. Wound cleansed with wound cleanser. Skin flap gently approximated. Calcium alginate (absorbent dressing) applied to wound bed and covered with foam dressing per treatment protocol. Resident tolerated treatment without difficulty. No acute signs and symptoms of infection noted at this time. Physician/Nurse Practitioner (NP) notified of new wound and treatment recommendations. Review of the resident's ePOS, showed:-An order, start date 06/19/26 and discontinued 06/24/26, for right gluteal (buttocks): Cleanse with wound cleanser, apply calcium, cover with bordered gauze. Daily and as needed as may be dislodged or saturated;-No treatment ordered for the right buttocks/gluteal area prior to 06/19/26. During an interview on 06/26/26 at 12:39 P.M., Licensed Practical Nurse (LPN) A said the resident was only here about a month and had a left or right foot wound. LPN A did not remember any other open areas. If a new open area was noted during skin assessments, nurses were to put in a consult and let the wound nurse and physician know. If the wound nurse was not there, then the nurse would assess the area and obtain measurements. The wound nurse normally gets to residents the next day, after a consult was entered. If the consult was entered on a Friday or Saturday, then the wound nurse would get to them on Monday. During an interview on 06/26/26 at 12:45 P.M., Certified Nursing Assistant (CNA) G said if staff found an open skin area on a resident, then staff were supposed to let the nurse know. During an interview on 06/26/26 at 12:50 P.M., the Director of Nursing (DON) said she found out about the resident's open area on his/her bottom on 06/18/26 when they were assessing his/her skin after his/her fall. The wound nurse told her about the open area. She never looked at it personally, so she did not know what it looked like. The resident's family insisted he/she be up in a chair and never wanted the resident to lay down so she would not be surprised if it was pressure ulcer. The DON expected for when a new wound was found, the wound nurse should assess and measure the wound and put in treatment orders. If it seemed like a bad wound, then the wound nurse would put in a wound consult and the wound NP that did rounds would assess and make determination if the resident needed to be put on wound rounds. The DON did not know if the resident's open area was a Stage II as documented on 06/05/26 or a skin tear as documented on 06/18/26. The nurses were doing weekly skin assessments, so she was confused about the one completed on the06/05/26 that showed Stage II pressure. Typically, the nurses were not supposed to stage wounds. During an interview on 06/26/26 at 1:40 P.M., the Administrator and DON said if a new area was found on a resident, they expected the wound nurse to assess the area and enter orders. If the resident had an area identified on 06/05/26, then they expected the assessment to have been completed and entered in the record before 06/18/26. If the wound was discovered on a Friday, then they expected the assessment to be completed first thing Monday morning. On the weekend, the floor nurse was expected to assess and put in orders and then the wound nurse would reassess Monday morning. If the wound nurse was out, then the DON or Assistant Director of Nursing (ADON) was expected to complete the assessment. If the area was truly a Stage II, then there should have been more documentation in the resident's record. The wound nurse found an open area on 06/18/26 when he/she did the skin assessment after the resident fell. The DON said the nurse that documented the skin assessment was a regular nurse. The DON was not sure why the nurse staged the wound. The nurses were not supposed to do that. The corporate staff provided a wound note dated 06/08/26 that was the assessment on the sacral area. She was trying to check to get confirmation and the note that would match this assessment. When asked about the assessment completed on 06/16/26, the DON and Administrator said that was only done because the family requested it to be done. 3034448