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	02/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bentwood Nursing & Rehab	1501 Charbonier Road Florissant, MO 63031

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on interview and record review, the facility failed to designate one or more individuals with specialized training in infection prevention and control as the Infection Preventionist for the facility's infection prevention control program. The census was 100.Review of the facility's Surveillance for Healthcare Associated Infection, dated 10/2021, showed:-Surveillance for Healthcare Associated Infections (HAI) will be completed to calculate baseline rates, detect outbreaks, track progress, and to determine trends to help prevent the development or spread of infections.- Complete the Monthly Infection Control Surveillance Log utilizing a new form each month or complete electronic version on medical record software. Complete the data as indicated;--Identifying the information i.e. resident's name;--admission date;--Infection onset date (may be onset of symptoms, if known, or date of positive diagnostic test);--Infection site (be as specific as possible, i.e. cutaneous infection should indicate pressure ulcer right foot, or respiratory infection as pneumonia RUL (right upper lobe));--Symptoms or related diagnosis;--Date of pre-treatment culture if known or indicated;--Identify the pathogen;--Record antibiotics or other treatment used;--Record any invasive, or high-risk procedures the resident may have had completed;--Identify if the infection was acquired outside the facility, i.e. community acquired;--Record other interventions;--Date infection resolved; -Perform the surveillance using any or all the following data gathering tools as possible indicators of nosocomial (health care associated) infections. (Note: Once an effective mechanism is identified, use the same methods to ensure meaningful trend data):Forward the Infection Control Surveillance Log to the Director of Nursing or Infection Control Designee, and RNC (Regional Nurse Consultant) at the end of each month;--Laboratory records;--Would evaluation ;--Infection control rounds or interviews; Pharmacy Records; --Hospital Transfer Logs; --Discharge Summaries;-The Monthly Infection Report will be provided to the facility Quality Assurance and Performance Improvement (QAPI) Team Members in the Quality Process Improvement Meeting;-The policy did not include having an Infection Preventionist. During interviews on 2/18/26 at 9:45 A.M. and on 2/24/26 at 11:15 A.M., the Director of Nursing (DON) said the Assistant Director of Nursing (ADON) would start courses to obtain certifications in wound care and infection perfection. The DON is working on getting her Infection Preventionist (IP) certification. The facility does not currently have an Infection Preventionist onsite.

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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure third party liability (TPL) forms were followed up on for the final accounting within 30 days for one of one sampled resident who expired (Resident #110). The sample was 22. The census was 100. Review of the facility's admission agreement, showed:-You have the right to manage your personal financial affairs or have someone you trust do so, including the facility. With your written approval, the facility will open a personal account for you through Resident Fund Management Services (RFMS). The personal resident trust account is controlled by you or your Resident Representative only. We will provide you with an accounting of these funds upon your request, and at least once every three months. Review of Resident #110's resident trust fund account, showed:-A balance of $4,708.23 as of [DATE];-Resident expired on [DATE];-A debit, in the amount of $4,698.95 on [DATE] for personal needs.-Closing interest in the amount of $1.36 on [DATE];-A debit, in the amount of $10.64 on [DATE], to close account. During an interview on [DATE] at 2:00 P.M., the Business Office Manager (BOM) said the resident's check was given to the family after they provided receipts for expenses for the resident's funeral. Review of the resident's trust record, received [DATE], showed:-A check, dated [DATE], in the amount of $4,698.95 to the pay to the resident's family member;-A receipt, dated [DATE], in the amount of $2,591.39 for repast (post funeral reception) at a Banquet Center;-A receipt, dated [DATE], in the amount of $210.50 for a Fossil watch at Macy's department store;-A receipt, dated [DATE], in the amount at $1,663.14 for a jacket ($698.00), blouse ($276.00), and pants ($648.00) at [NAME] Fifth Avenue;-A receipt, dated [DATE], in the amount of $93.92 for a full slip ($69.00) and unidentified item ($18.00) at JC [NAME];-A receipt, dated [DATE], in the amount of $140.00 from a funeral home for obituaries. During an interview on [DATE] at 8:36 A.M., the Business Office Manager said when a resident expires, the family will request funds for funeral expenses. Anything that was left they will send to TPL. If a resident has a credit balance, he/she will send it to TPL. When the resident expired, he/she asked if it was okay to give the resident's money to the family. The Regional manager said it was fine as long as they provide receipts, and the family submitted the receipts. They had expenses for the funeral and wanted to purchase clothes to [NAME] to the resident in. He/She said the family wanted the resident to dress fancy; however, he/she did not know why the family purchased a full slip from JC [NAME] if a jacket and pants were also purchased at [NAME] Fifth Avenue. The BOM checked the receipts when they were submitted but did not have a conversation with corporate BOM about it. The check was printed at the facility level and given to the resident's family. The BOM said corporate was not involved at that point. During an interview on [DATE] at 12:58 P.M, the Administrator said he would expect the BOM to send the resident's funds to TPL if it was not used for funeral expenses. He would expect the money to be sent back to the state. They were told that the resident was fancy and they wanted the resident to look nice. Intake number: 1550386

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents who required assistance with activities of daily living (ADLs) received personal hygiene assistance in accordance with their personal needs. The facility failed to ensure one resident received showers, was dressed in clothing, and was assisted out of bed (Resident #40) and failed to ensure one resident received nail care and facial hair was removed (Resident #98). The sample was 22. The census was 100. Review of the facility's nail care policy, dated 7/21/22, showed:-Policy: the purpose of nail care is to clean the nail bed, trim nails, and prevent infection;-Key Points: nails may be cleaned during bathing. Nail care includes daily cleaning and regular trimming. Stop and report to the Charge Nurse ingrown nails, infection, pain, or nails that are thick and difficult to trim. Review of the facility's ADL care bathing policy, dated 7/21/22, showed:-Policy: nursing staff will assist in bathing residents to promote cleanliness and dignity. The Charge Nurse will be made aware of residents who refuse bathing;-Procedure: observe the residents skin for any redness, rashes, broken skin, tender places, irritation, reddish or blue-gray area of skin over a pressure point. blisters, or skin breakdown. Soap has a drying effect on the skin. Be sure to rinse the skin well. Be gentle and do not rush the procedure; allow for breaks if needed. 1. Review of Resident #40's quarterly minimum data set (MDS), a federally mandated assessment tool completed by facility staff, dated, 11/30/25, showed:-No rejections in care;-Dependent on staff for bed to chair transfers, toilet hygiene, bathing, and upper and lower body dressing;-Requires moderate assistance with personal hygiene;-Diagnosis include hemiplegia (weakness to one side of the body), aphasia (inability to speak) and stroke. Review of the resident's care plan, in use at the time of survey showed:-Focus: The resident has ADL self-care deficit related to stroke and limited mobility;-Interventions: Offer bathing or showering twice a week; Requires staff to assist with dressing; Transfer resident using a Hoyer (a mechanical lift).The resident's care plan did not show the resident refuses ADL care from facility staff. Review of the resident's Certified Nursing Assistant (CNA) skin monitoring and bathing review sheets dated 2/1 through 2/23/26 showed the resident received a bed bath on 2/2, 2/5, 2/12, and 2/23/26. During observation on 2/18/26 at 11:19 A.M., 2/19/26 at 12:05 P.M., and 2/20/26 at 10:00 A.M., and 2/24/26 at 6:20 A.M., the resident lay in bed with the room dark. The resident wore a green hospital gown with food stains. Observation and interview on 2/23/26 at 5:10 P.M., the resident lay in bed with the room dark. The resident wore a green hospital gown with food stains. The resident's right eye was crusted with white matter. The resident raised his/her left arm during the interview, and a strong body odor was present. The resident nodded yes when asked if he/she would like to get out of bed. During an interview on 2/23/26 at approximately 12:30 P.M., CNA J said the resident requires assistance from staff getting dressed, bathing and getting out of bed. CNA J said the resident usually refuses to get out of bed or get dressed. The resident receives a bed bath twice a week. CNA J said he/she changes the resident's gown every day he/she works. During an interview on 2/24/25 at approximately 9:00 A.M., CNA H said the resident is provided a bed bath twice a week and will only get out of bed occasionally. The resident has clothing in his/her closet. The resident should be offered to change out of the hospital gown and get out of bed daily. If the resident refuses the nurse is notified. During an interview on 2/24/26 at 10:50 A.M., the Director of Nursing (DON) said she would expect staff to provide the residents a bed bath or shower twice a week. She would expect residents to be clean, dry and odor free every day. The DON would expect staff to offer the resident to change into their personal clothing and get out of bed every day. If the resident refuses ADL care, it is expected to be included in the resident's care plan. 2. Review of Resident #98's quarterly MDS, dated [DATE], showed:-Severe cognitive impairment;-Dependent on staff for personal hygiene care;-Diagnoses included Alzheimer's disease, heart failure, depression, and muscle weakness; Review of the resident's care plan, in use at the time of the survey, showed:-Focus: resident has an ADL self-care (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	performance deficit;-Goal: resident will maintain current level of function with ADLS through the review date;-Interventions: offer bathing/showering twice weekly and as necessary.Check nail length and trim and clean on bath day and as necessary. Report anychanges to the nurse. Observation on 2/18/26 at 10:49 A.M., showed the resident in bed asleep. The resident's fingernails were long and jagged with chipped nail polish. The resident had facial hair around his/her lips and on his/her chin. Observation on 2/20/26 at 11:20 A.M., showed the resident sat in his/her wheelchair at the nurse's station. The resident's fingernails were long and jagged with chipped nail polish. The resident had facial hair around his/her lips and on his/her chin. During an interview on 2/23/26 at 8:02 A.M., Licensed Practical Nurse A said resident fingernails should be kept clean and trimmed to the resident's liking. He/She would expect resident's facial hair to be trimmed/ shaved. During an interview on 2/23/26 at 8:13 A.M., the DON said she would expect residents to have clean fingernails. She would expect nursing staff to trim or file resident's nails if they are jagged. She would expect staff to shave the resident's facial hair upon request or use nursing judgement if the resident was unable to communicate.

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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 observation, interview and record review, the facility failed to ensure physician's order(s) were followed for treatments related to a post-surgical site for a resident's left hand. For one of three residents sampled (Resident #81). The sample was 22. The census was 100. Review of the facility's Physician Order Policy, dated 10/2022, showed:-Policy: To provide guidance and ensure physician orders are transcribed and implemented in accordance with professional standards, State & Federal guidelines;-Responsibility: Licensed Nurses- Registered Nurse (RN) and License Practical Nurse (LPN), Nursing Administration, & Director of Nursing (DON);-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. The required components of a complete Order: Date and time of order, name of practitioner providing order, name and strength of medication/treatment, quantity/duration, dosage/frequency, route of administration, indication/diagnosis;-Physician Order Sheet will be maintained with current physician orders as new orders are received. Discontinued orders will be marked as discontinued with the date, and all new orders will be written in the appropriate area on the physician order sheet with the date the order was received;---Physician orders will be transcribed to the appropriate electronic medication administration record (MAR) or electronic treatment administration record (TAR). Review of the facility's Wound Management Policy, dated November 2025, showed:-To promote Wound healing of various types of Wounds, the Facility will provide evidence-based treatments in accordance with current standards of practice and physicians orders.-Procedure: Wound Treatment will be provided in accordance with physician's order: Cleaning method, type of dressing, frequency of dressing change. Review of Resident's #81's medical record, showed diagnoses included absence of left finger, stroke, cognitive communication deficit (impaired communication), need for assistance, atrial fibrillation (irregular heartbeat), kidney disease and muscle weakness. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/31/25, showed:-Cognitively intact;-Number of ulcers, wounds and other skin conditions: none present;-Skin and ulcer/injury treatment(s): application of nonsurgical dressing. Review of the resident's care plan, in use during survey, showed:-Focus: He/She has an arterial wound on the left hand fingers 2-5;-Goal: The resident will be free from infection or complications related to arterial ulcer through review date;-Interventions: Monitor/document/ report as needed any signs and symptoms for infection. Weekly treatment(s) documentation to include measurements of each area of skin breakdown width, length, depth, type of tissue and exudate (drainage that is infected) and any other notable changes or observations. Review of the resident's hospital discharge paperwork, dated 9/11/25, showed the resident had left ring finger dry gangrene (tissue death) related to chronic (long term) digital (finger) ischemia (lack of blood flow). Special instructions: Hand hygiene is a must especially pre and post bandage change. Review of the resident's TAR, dated October 2025, showed an order dated 10/21/25, for Xeroform Petrolate (sterile, non-adherent, fine-mesh gauze infused with medication), apply to left hand between fingers topically one time a day, fold 1 pad externally: Wound care not documented as completed 11 out of 11 opportunities. Review of the resident's wound physician initial evaluation and management summary, dated 11/5/25, showed:-Post surgical wound of the left, fourth (ring finger) amputation 3.5 centimeters (cm) by 1cm by 3 cm; heavy serosanguinous (clear bloody drainage);-Treatment order: cleanse with wound cleaner apply once daily: if saturated (visibly dirty with bodily fluids), soiled, or dislodged use collagen powered daily and as needed (PRN), alginate calcium (highly absorbent, seaweed-derived fibers used for moderate-to-heavy exuding wounds);-Second dressing use gauze (sterile dressing), apply once daily, and PRN: if saturated, soiled, dislodged; Review of the resident's MAR, dated November 2025, showed:-An order date 10/21/25 and discontinued 11/13/26, for Xeroform Petrolate patch apply to left hand between fingers topically one time a day: Wound care not documented as completed 13 out of 13 opportunities;-An (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	order date 11/13/25 and discontinued 11/15/26, for left 4th amputation of finger: Clean area with wound cleaner and pat dry, stack 4X4, cover with Alginate Calcium, top with collagen powder cover powder with 1 gauze 4X4, apply to amputation site. Wrap with kerlix (gauze wrap) secure with tape. Change daily and if dislodged or soiled PRN for wound care: Wound care not documented as completed 3 out of 3 opportunities;-The resident on hospital leave from 11/14 through 11/18/26;-An order dated 11/20/25 and discontinued 12/1/25, for Xeroform Petrolate patch. Apply to left ring finger topically, one time a day. Cleanse left ring finger with normal saline. Apply xeroform and Kling (gauze wrap) daily: Wound care not documented as completed four out of 11 opportunities. Review of the resident's wound physician management summary, dated 11/26/25, showed:-Post surgical wound of the left, fourth ring finger amputation 3.5 cm by 0.6 cm by 0.5 cm; light serosanguinous; improved evidenced by decreased depth;-Treatment Plan:--Betadine apply once daily and as needed: if saturated, soiled, or dislodged. For 30 days; Xeroform gauze apply once daily and as needed: if saturated, soiled, or dislodged. For 30 days: Single layer. Avoid trauma or bleeding during dressing changes;--Gauze sponge sterile apply once daily and as needed: if saturated, soiled, or dislodged. For 9 days; Gauze roll (kerlix) 4.5 apply once daily and as needed: if saturated, soiled, or dislodged. For 9 days; Tape (retention) apply once daily and as needed: if saturated, soiled, or dislodged. For 9 days. Review of the resident's wound physician management summary, dated 12/3/25, showed:-The progress of this wound and the context surrounding the progress were considered in greater detail today. The patient's advancing peripheral arterial disease/gangrene significantly increases their susceptibility to complications and poor prognosis. Patient presents deterioration of necrotic tissue. Please refer him/her to a surgical consult.-Post surgical wound of the left, fourth ring finger amputation 6.5 cm by 0.9 cm by 0.5 cm; moderate serosanguinous; exacerbation due to arterial. Review of the resident's wound physician management summary, dated 12/31/25, showed:-Left hand surgery scheduled for 1/8/26;-Wound sized 13 cm by 7 cm by 0.6 cm; Review of the resident's MAR, dated January 2026, showed:-An order dated 1/1/26 and discontinued 1/21/26, for left 2nd through 5th finger. Clean area with wound cleanser and pat dry, paint with betadine, cover with gauze, secure with tape, then apply ace wrap. Change daily or if soiled or dislodged: Not documented as completed on 1/19 or 1/21/26;-An order dated 1/22/26 showed, for left 2nd through 5th finger: Clean with wound cleaner and pat dry, paint with betadine, apply collagen powder to open area (amputation site), cover with gauze, secure with tape, then apply ace wrap change every day or if soiled or dislodge: Wound care not documented as completed four out of 10 opportunities. Review of the resident's wound physician management summary, dated 1/21/25, showed:-Wound is improving 10.4 cm by 6.5 cm by 0.6 cm;-Treatments Plan;--Primary Dressing(s): Betadine apply once daily and as needed: if saturated, soiled, or dislodged. For 30 days: In the gangrene fingers; Gauze sponge sterile apply once daily and as needed: if saturated, soiled, or dislodged. For 30 days: Non-woven gauze; Collagen powder applied once daily and as needed: if saturated, soiled, or dislodged. For 30 days: Only on the granulation tissue.--Secondary Dressing(s): Gauze roll (kerlix) 4.5 apply once daily and as needed: if saturated, soiled, or dislodged. For 30 days; Tape (retention) apply once daily and as needed: if saturated, soiled, or dislodged. For 30 days. Review of the resident's medical record, showed the resident on hospital leave from 1/28 through 2/6/26. Review of the resident's MAR, dated February 2026, reviewed on 2/20/26, showed:-No wound care ordered or documented as completed from 2/6/26 through 2/9/26;-An order date 2/10/26 showed: Cleans Left index, middle and ring finger with wound cleanser. Pat dry. Apply betadine-soaked gauze, dry dressing and wrap with kerlix daily and PRN one time a day for wound care: Wound care not documented as completed eight out of 10 opportunities. Review of the resident's wound physician management summary, dated 2/10/25, showed arterial wound of the left, 2nd through 5th fingers, gangrene finger. The vascular procedure was discussed, possible fingers amputation and surgical follow up. Observation 2/19/26 at 10:09 A.M., showed the Wound Nurse entered the resident's room to provide wound care. The current dressing on the resident's left hand had no date, time or initial from the previous dressing change to show when it (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was last changed. The Wound Nurse completed the treatment as ordered. The resident's fingernails were long and curled up inside the palm of his/her hand. The Wound Nurse documented the date on the new dressing. During an interview on 2/19/26 at 10:09 A.M., the Wound Nurse said the podiatrist does not want the fingernails clipped. Also, the resident is re-scheduled for surgery for amputation. Staff are required the date of the dressing when changed. During an interview on 2/23/26 at 7:38 A.M., The Wound Specialist said the resident's uncontrolled diabetes and diagnosis of necrotic fingers on the left had complicated things. He/she was under the direct care of the surgeon. She was removed from the case while the resident was under the care of the surgeon. She was not consulted again on the case until January 28, 2026. The resident had a complication and went back to the hospital and that was the last time she saw the resident. Treatments not being done as ordered post-surgical could cause harm to the wound. During an interview on 2/24/26 at 8:44 A.M., the Assistant Director of Nursing (ADON) said every shift wound treatments should be completed. If the resident refused, staff should notify the medical director, inform the oncoming staff nurse, and place a progress note into the electronical medal record. Nurses are expected to put in a progress note about the wound dressing when completed. 2721422

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview and record review, the facility failed to ensure physician's orders were followed for treatments, pressure reducing boots in place, and the air mattress set no higher than the resident's weight, for one of three sampled residents for wounds (Resident #25). The sample was 22. The census was 100.Review of the facility's Wound Management Policy, dated November 2025, showed:-To promote wound healing of various types of wounds, the facility will provide evidence-base treatments in accordance with current Standards of Practice and physicians orders.-Procedure:--Wound Management:---Wound treatment will be provided in accordance with physician's order;---Cleaning method;---Type of dressing;---Frequency of dressing change;--Charge Nurse will notify Physician in the absence of treatment orders;--Dressing changes may be provided outside the frequency parameter in certain situations;---Urine, feces, or other bodily fluids have saturated through the dressing;---Dressing is dislodged;---Dressing is soiled;--Wound characteristics/documentation;---Location of the wound;---Pressure injury & stage;---Non-Pressure-Level of tissue destruction;---Size (shape, depth, tunneling and/or undermining (tissue destruction beneath the skin surface at the wound edge). Volume and exudate (drainage) Characteristics;---Pain evaluation;---Presence of infection/bioburden (amount of microorganisms);---Condition of the wound bed and wound edges;---Condition of the peri-wound (area around the wound);---Resident/Resident Representative preferences/goals. Review of Resident's #25's medical record, showed diagnoses included abnormal posture, cognitive communication deficit (impaired communication), need for personal assistance, pain in joints, paraplegia (impaired motor and sensory in lower extremities), and diabetes. Review of the resident's annual minimum data set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/16/26, showed:-admission date 8/10/24;-Severely cognitively impaired;-Weight charted as 167 pounds (lbs.);-Dependent assistance required for activities of daily living (ADLs);-Resident has pressure injuries over bony prominence, or non-removable dressing/devices;-No other ulcers, wounds and skin problems noted;-Skin and ulcer/injury treatments are pressure reducing device for wheelchair (w/c) and pressure reducing for bed;--Number of stage 3 pressure ulcer (severe, full-thickness skin injury appearing as a deep, open, crater-like wound where subcutaneous fat is visible, but muscle, tendon, or bone are not), three are present, but not present upon admission;--Number of stage 4 pressure ulcer (severe, full-thickness wound extending to exposed bone, tendon, or muscle, often featuring deep tissue damage, tunneling, and high infection risk), one is present, but not present upon admission. Review for the resident's care plan, in use during survey, showed:-Focus: Resident has a stage 4 pressure wound to his/her left buttocks, stage 3 pressure wound of the left medial (middle) buttocks, stage 3 sacrum/ coccyx (above buttocks) unstageable deep tissue injury (DTIs) left lateral (side) ankle, and foot; delayed healing due to diabetes, immobility and incontinence;-Goal: Wound(s) will remain free from infection;-Interventions: Administer treatments as ordered and monitor for effectiveness, low air loss mattress bed, and position pillows in place, off-load wound (reduce the pressure) as tolerated, side-to-side turning, treatments as ordered. Review of the resident's physician order sheets (POS), dated February 2026, showed:-An order dated, 9/18/24, for wound consult;-An order dated 9/18/24, low air loss (LAL) mattress to bed and check settings every shift;-An order dated 7/1/25, air mattress for preventative measures;-An order dated 9/19/25, complete a skin assessment every Thursday on day shift;-An order dated 1/5/26, wound consult as needed to evaluate and treat;-An order dated 1/10/26, Prevalon protection boots bilateral foot at all times;-An order dated 1/14/26, lateral left foot: Clean with cleanser and pat dry, apply alginate honey (sterile wound care products that combine the high absorbency of seaweed-derived calcium alginate with the antimicrobial/healing properties of honey) cover with gauze and wrap with kerlix (cotton gauze roll featuring a unique crinkle-weave pattern), change every day (QD);-An order dated 1/21/26, left medial buttocks: Clean with soap and water, apply barrier every shift;-An order dated 2/8/26, left lateral (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bentwood Nursing & Rehab	1501 Charbonier Road Florissant, MO 63031

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ankle clean with wound cleaner and pat dry apply collagen powder (topical treatment that speeds healing) cover with alginate calcium (highly absorbent, seaweed-derived fibers used for moderate-to-heavy exuding wounds, such as ulcers and burns) then gauze and wrap with kerlix, change every two days (q2d);-An order dated 2/8/26, left buttocks: Clean with Vashe (solution to cleanse, irrigate, and debride acute/chronic wounds) pat dry, apply collagen with calcium (Ca+) alginate silver (highly absorbent, antimicrobial, conformable wound dressing made from seaweed fibers and ionic silver. It manages moderate to heavy exudate by turning into a gel);-An order dated 2/8/26, sacrum: Clean area with Vashe pat dry, apply collagen power with Ca+ silver then superabsorbent fiber with silicone border, change twice daily (BID). Review of the resident's medication administration record (MAR), dated February 2026, showed:-Left lateral ankle, clean with wound cleaner and pat dry, apply collagen powder cover with alginate calcium then gauze and wrap with kerlix, change Q2D, missed two out of three opportunities;-Left lateral foot, clean with wound cleanser and pat dry, apply alginate honey cover with gauze and wrap with kerlix, change every day and every day shift every other day (how it is written in the MAR) for wound care, missed five out of 11 opportunities;-Left medial buttock: Clean with soap and water, apply barrier every shift for wound care, missed 18 out of 45 opportunities;-Left buttock: Clean with Vashe, pat dry, apply collagen powder with Ca+ alginate silver then superabsorbent fibers with silicone border BID, missed 14 out of 30 opportunities;-Sacrum: Clean area with Vashe and pat dry apply collagen powder and cover with Ca+ alginate then gauze and superabsorbent fiber with silicone border, change BID, missed 43 out of 44 opportunities;-Prevalon protective boots on bilateral feet at all times, every shift for skin integrity, protects bony prominences to bilateral legs, missed 17 out of 46 opportunities. Review of the wound doctor's progress note, dated 2/18/26 at 8:23 A.M., showed:-General recommendations of reposition per facility's protocol;--Off-load wound(s): pillows underneath left knee;--Turn side-to-side in bed;--Float heels in bed;-Specific to visit recommendations;--Other: 12/24/25, please keep mattress settings per patient's weight;--Other: 12/31/25, please have Certified Nurse's Assistant (CNA) to clean with wipes saturated with soap and water, for personal hygiene and incontinence. Observation on 2/18/26 at 12:00 P.M., showed the resident wore a brief (incontinent absorbent garment) and the catheter tubing was visible. The resident had no protective boots on. Observation on 2/19/26 at 9:38 A.M., showed the following:-The resident's air mattress was set to 350 pounds;-The resident's left hip bandage had no date, or time and drainage soaked through the bandage;-The resident's left ankle had brown and bloody drainage and the bandage was dated 2/18 without a time;-Staff turned the resident. During an interview on 2/19/26 at 9:38 A.M., the Wound Nurse said the left ankle had serosanguinous (serum and small amounts of blood) drainage. The dressing was brown and dried at the left ankle and dated 2/18. If staff see a soiled dressing, they should change it. The wound was debrided (remove damaged tissue or foreign objects from) yesterday which would increase the drainage of the wound. Observation on 2/19/26 at 1:41 P.M., showed the resident lay on his/her left side without protective boots on, and air mattress settings were set at 350 lbs. Observations on 2/20/26 at 5:37 A.M. and at 6:34 A.M., showed the resident's air mattress was set at 350 pounds (lbs.) At 6:34 A.M., the resident did not have protective boots on. Observation on 2/20/26 at 6:34 A.M., showed the Wound Nurse rolled the resident over, and the Wound Nurse and Assistant Director of Nurses (ADON) changed the resident's dressings. The resident had a residue of barrier cream around his/her rectum. The wound nurse cleaned the wounds on the resident's coccyx/sacrum area, but did not clean the surface around the wounds by the barrier cream residue left on the resident. Observation on 2/20/26 at 9:06 A.M., showed the resident had no protective boots on, and the air mattress blinked red and showed power failure. The bed was still inflated. At 9:29 A.M., the resident did not have his/her protective boots on. Observation on 2/20/26 at 1:34 P.M., showed the resident's mattress was off, no lights were on the control monitor, but the bed was still inflated During an interview on 2/22/26 at 9:29 A.M., CNA D said, he/she was unaware if the resident had an order for protective boots, but they were in stock. CNA D said, the resident has never laid on his/her right since he/she has been employed. Observation (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 2/23/26 at 6:45 A.M., showed the resident's air mattress was beeping, and the monitor said failure. The mattress felt deflated. The resident did not have his/her protective boots on while he/she lay in bed. During observation and interview on 2/23/26 at 8:58 A.M., the resident's air mattress was completely deflated, and the resident complained about his/her left arm pain. Maintenance Employee E said he/she just got the ticket to fix the bed. Observation on 2/23/26 at 9:31 A.M., showed the resident's bed settings were set at 490 lbs. with rotation every 15 minutes, while he/she lay in bed. Observation on 2/23/26 at 10:30 A.M., showed the resident had no protective boots on, and his/her wound dressings were dated Friday 2/20/26 at 6:55 A.M. The Director of Nursing (DON) reviewed the bed control panel and confirmed the settings at 490 lbs were out of range for the resident's weight. During an interview on 2/23/26 at 10:30 A.M., the DON said, she would 100% expect the air mattress to be within range of the resident's weight. She would expect no brief on a resident who had a suprapubic catheter and wound to his/her buttocks. A brief is a contraindication because the resident has wounds and a catheter. The dressing to the resident's left hip was heavy serosanguinous drainage, and there was heavy drainage coming from his/her left ankle dressing. The Wound Nurse would now change the dressings and notify the wound doctor of the dressing not changed over the weekend. The DON expected staff to use protective boots for the resident, since a physician's order was in place. During an interview on 2/23/2026 at 7:38 A.M., the Wound Physician said the resident's pressure wounds have been present for a while. He/She favored the left side. His/Her challenge was repositioning. The Wound Physician said, offloading was very important, and she recommended protective boots as the best practice. She would expect the air mattress be set at the patient's weight and no higher. There are new CNAs who are not aware why the beds needed to be at the recommended weight levels. She wished there was a system for staff to check off loading residents. The Wound Physician said staff believe placing the air mattress at a higher level or all the way up was good; that is the perception, but that is not accurate. During an interview on 2/24/26 at 8:44 A.M., the ADON said every shift wound treatments should be completed. If a resident refuses, staff were expected to notify the medical director, oncoming nurse and place a progress note in the record. Interventions should be followed. If the mattress is too firm, the mattress can cause more pressure to the resident's skin. 2721422

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, interview and record review, the facility failed to provide one resident (Resident #40), who had limited mobility, the appropriate services, equipment and assistance to maintain or improve their mobility. The sample was 22. The census was 100.During an interview on 2/24/26 at approximately 9:00 A.M., the Director of Nursing (DON) said the facility did not have a restorative therapy (RT) policy that focuses on regaining or maintaining physical function. Review of Resident #40's quarterly Minimum Data Set (MDS), a federally mandated assessment completed by facility staff, dated 11/30/25, showed:-No rejection of care;-Functional limitation of range of motion: No impairment to the upper extremities. Impairment on both sides of the lower extremity;-Dependent on staff for bed to chair transfers, toilet hygiene, bathing, and upper and lower body dressing;-Requires moderate assistance with personal hygiene;-Diagnosis include hemiplegia (weakness to one side of the body), aphasia (inability to speak) and stroke. Review of the resident's care plan, in use at the time of survey, showed:-Focus: The resident has an activity of daily living (ADL) self-care deficit related to stroke and limited mobility;--Interventions: Offer bathing or showering twice a week; Requires staff to assist with dressing; Transfer resident using a Hoyer (a mechanical lift).-Focus: The resident is at risk for falls related to gait and balance problems;--Interventions: Physical therapy to treat as ordered and as needed. -The care plan did not show the resident refusing ADL care from facility staff. Review of the facility's list of RT case load, dated 2/9/26, did not show the resident listed. Observation on 2/18/26 at 11:19 A.M., and 2/23/26 at 5:10 P.M., showed the resident lay in bed. The resident's right arm was bent and positioned close to his/her body. The resident's right hand was tightly clenched. The resident was unable to open his/her right hand or move his/her right arm when requested. During an interview on 2/23/26 at approximately 12:30 P.M., Certified Nursing Assistant (CNA) J said the resident requires assistance from staff getting dressed, bathing and getting out of bed. The resident is unable to move his/her right arm. The resident will usually not let anyone touch his/her right arm due to pain when he/she moves it. CNA J said he/she has never seen splints or therapy work with the resident. During an interview on 2/23/26 at 5:00 P.M., Licensed Practical Nurse (LPN) M said he/she has provided care to the resident and thinks that a splint or RT would be appropriate and helpful to the resident. The resident guards his/her right arm at times due to pain when the resident moves it. Nursing staff should let the therapy department and the physician know if the resident needs to be screened for any type of therapy. During an interview on 2/24/26 at 9:50 A.M., Restorative Aide (RA) N said the resident was not on his/her current workload. The therapy department gives them a list of residents that require RT. The resident requires a Hoyer lift for transfers and RA N will occasionally assist with the resident's transfer. The resident has a history of refusing care. The resident's arm and hand are contracted and would benefit from RT. During an interview on 2/23/26 at approximately 1:00 P.M., the Therapy Director said she was not familiar with resident. The last time the resident was seen by the therapy department was 6/12/24 through 9/19/24. She would have expected the staff to notify the therapy department that the resident was having difficulty moving his/her right arm and hand so that therapy could screen the resident and make the appropriate recommendations and interventions. During an interview on 2/25/26 at 10:50 A.M., the DON said she would expect the resident to receive some type of therapy, device or intervention to help with the mobility of the resident's right arm and hand. The resident may require a type of topical pain medication to assist with movement of his/her arm and hand. Any refusal of ADL care is expected to be in the resident's care plan.

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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. Based on observation, interview and record review, the facility failed to provide a safe transfer technique for two residents who required assistance with transfers. Staff failed to ensure a gait belt was use for one resident (Resident #19). In addition, staff failed to ensure two staff transported a resident by mechanical lift (Resident #14) after a family member was observed assisting staff. The sample was 22. The census was 100. Review of the facility's Gait Belt Transfer policy last reviewed,10/25/22, showed:-Policy: the facility will utilize a gait belt for residents who require one assist with transfer to promote safety during resident transfers;-Procedure: -Ensure the resident is wearing non-skid footwear; -Place the gait belt around the resident's waist over their clothing with the buckle facing the front; -Buckle and fasten the gait belt; -Position your body close to the resident; -Transfer the resident by grasping the gait belt using an underhand grip; -While firmly gripping the gait belt, staff should keep their back straight and bend knees slightly with feet in a wide stance to maintain proper body mechanics; -Begin to rock back and forth and instruct the resident ton the count of three to push off the surface; -Allow the resident to pivot and to bear weight; -Guide the resident to the destination surface; -Keeping a firm grip on the gait belt, gently lower the resident onto the surface; -Assist the resident to a comfortable position. 1. Review of Resident #19's care plan, in use at the time of survey, showed:-Focus: The resident has a self-care performance deficit related to activities of daily living (ADL);-Interventions: The resident requires one person assistance with transfers and toileting. Review of the resident's medical record, showed diagnoses that included fracture of right arm, unsteadiness on feet, muscle weakness, and hemiplegia (weakness) of the right arm and Alzheimer's disease. During observation on 2/20/26 at 6:30 A.M., the resident lay in bed. The resident's right arm showed a soft cast. Certified Nursing Assistant (CNA) F assisted the resident to the side of the bed. CNA F placed slippers on the resident and positioned his/her hands under the resident's arms and lifted the resident up off the bed. The resident was unable to stand upright, and the resident's feet were sliding on the floor. CNA F instructed the resident to stand up. The resident was unable to straighten his/her knees. CNA F pivoted the resident to the resident's wheelchair by holding the resident under his/her arms. CNA F propelled the resident into the bathroom and lifted the resident out of his/her wheelchair by holding the resident under his/her arms and placed the resident on the toilet. Once the resident was done using the toilet, CNA F asked for help from CNA G to assist the resident off of the toilet. CNA F and CNA G stood on each side of the resident and lifted the resident off the toilet by holding the resident under his/her arms. CNA F and CNA G pivoted the resident into his/her wheelchair. CNA F and CNA G did not use a gait belt while transferring the resident. During an interview on 2/24/26 at approximately 9:00A.M., CNA H said gait belts are to be used anytime the resident requires assistance transferring. The gait belt provides stability for the resident and allows the staff member to safely lower the resident to the floor or chair if the resident's knees buckled. Resident #19 requires a gait belt for all transfers. During an interview on 2/24/26 at 10:25 A.M., Certified Medicine Technician (CMT) I said a gait belt is to be used anytime the resident requires assistance from staff to transfer. The gait belt is used so that staff is not pulling on the resident. Transferring the resident by holding them under their arms is not a good or proper transfer technique. The gait belt is also a safety device so that in case the resident starts to fall the staff member can use the gait belt to safely lower the resident to the floor. It also gives the resident a sense of security. During an interview with on 2/24/26 at 10:50 A.M., the Director of Nursing (DON) said there are gait belts located on the supply carts on each of the halls. She would expect the staff to use a gait belt on all residents requiring assistance with transfers. She would have expected staff to use a gait belt while transferring Resident #19. 2. Review of Resident #14's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 1/21/26, showed:-Cognitively intact;-Has indwelling catheter;-Diagnoses included cancer, high blood pressure, (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	obstructive uropathy (a blockage in the urinary tract that hinders urine flow), viral hepatitis, diabetes, hyperlipidemia (high cholesterol in the blood), hemiplegia (paralysis affecting one side of the body), anxiety, depression;-Impairment on one side to the lower extremity;-Uses wheelchair;-Total dependent with personal hygiene and toileting hygiene;-Total dependent with transfers. Review of the resident's care plan, in use during survey, showed:-Focus: Safety: Resident requires a Hoyer (mechanical) lift for transfers. Requires two person assist at all times during transfers. Use a large lift sling;-Goal: Resident will remain safe;-Interventions: Requires two person assist at all times during transfers. Observation on 2/23/26 at 8:34 A.M., showed the resident's family member exited from the room, wearing gloves. CNA R exited the room and returned to the resident's room with a mechanical lift. There was no other staff seen inside the resident's room. CNA R donned PPE outside of the resident's room and closed the door; however, the door did not latch and opened up. CNA R was observed operating the mechanical lift while assisted by the resident's family member. The resident's wheelchair was moved in front the open door while CNA R operated the lift to lower the resident as the family member assisted the resident into the electric wheelchair. At 8:42 A.M., CNA R doffed the PPE and placed it into the bin. There was no other staff seen inside the resident's room. The resident's family member was seen in front of the door assisting the resident and re-positioning him/her into the wheelchair. CNA R returned to the room and removed the mechanical lift out of the resident's room and placed it in the hallway. During an interview on 2/23/26 at 8:51 A.M., CNA R confirmed the resident's family member assists with the resident's care. He/She was unsure if the family member was able to assist with transfers or trained. He/She confirmed the resident's family member helped with the mechanical lift transfer. He/She asked staff for help, but no one was available. The job had to get done. During an interview on 2/24/26 at 8:00 A.M., the DON said they became aware the resident's family assisted with mechanical lift transfers. The aides did not know what to do. They did not know they could say stop to the family. The family member used to have the resident at home and had a mechanical lift there, so it was done at home. Staff think they cannot say no to family. A nurse mentioned that they would not know what to tell a family member. She would expect staff to follow policy and only staff to transfer residents. The resident's family member is very involved and will often grab gloves and start doing care. They will need to have a care plan meeting with the family member.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure supra pubic catheter (medical device used to collect bodily waste) care was provided by staff and physician orders were obtained for a gauze to cover the site for one resident (Resident #25). The facility also failed to ensure one resident with a Foley catheter (a flexible, indwelling tube inserted through the urethra into the bladder to drain urine into a bag, held in place by a small, water-filled balloon) had appropriate physician's orders for the catheter, catheter tube change, and urine output (Resident #14). The facility identified three residents with a catheter, two were sampled and issues were identified with both residents. The sample was 22. The census was 100. Review of the facility's Catheter Care Policy, dated July 2022, showed:Policy: The Facility will maintain consistent and adequate hygiene standards for residents with Indwelling Catheter to maintain function and prevention of infection or complications;-Responsibility: Nursing Staff, Licensed Nurses Registered Nurse (RN) and Licensed Nurse Practical (LPN), Administration and Director of Nursing (DON);-Procedure: Gather Supplies: Towel, incontinent Wipes, Incontinent Pad;--Identify Resident & Explain Procedure;--Provide Privacy;--Perform Hand Hygiene & Apply Gloves;--If able, Position Female Resident in the Dorsal Recumbent (on their side) Position; Males in the Supine (on their backs); Position. Place Incontinent Pad under Resident's Hips;--Place sheet over Resident; Only exposing Perineal Area;--Perform Incontinence Care per facility protocol prior to providing Catheter Care;-Female: With non-dominant hand, retract labia to fully expose urethral meatus and Catheter insertion site. Maintain hand position throughout the procedure;-- Cleanse the labia major (he larger outer folds of the vulva) using soap and water and a clean washcloth, cleanse downward motion. Change the position of the washcloth with each downward stroke;--Repeat for the labia minor using a clean washcloth cleansing down the length of the Catheter at least 4;--Do not allow the washcloth to drag on resident's skin or bed linen;-Men: Retract the foreskin of the uncircumcised penis to expose urethral meatus and Catheter insertion site. Maintain hand position throughout the procedure;--Cleanse the urethral meatus using soap and water and a clean washcloth down the length of the catheter at least 4. Cleanse glans using circular strokes from the meatus outward. Change the position of the washcloth with each cleansing stroke;--With a clean washcloth, rinse with warm water using the above technique;--Return foreskin to normal position. 1. Review of Resident's #25's medical record, showed diagnoses included neuromuscular dysfunction of bladder (loss of normal bladder function, nerve damage between brain and bladder), retention of urine (inability to empty bladder), cognitive communication deficit (impaired communication), need for personal assistance, pain in joints, paraplegia (impaired motor and sensory in lower extremities), and diabetes. Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility staff, dated 2/16/26, showed:-Severely cognitively impaired;-Dependent assistance required for activities of daily living (ADLs);-Indwelling catheter. Review for the resident's care plan, in use during survey, showed:-Focus: Requires catheterization suprapubic catheter due to neurogenic bladder;-Goal: Resident will show no signs/symptoms of urinary tract infection (UTI);-Interventions: Position catheter bag away from door entrance. Monitor/document for pain and discomfort due to catheter. Supra-pubic catheter changes as directed with 10 cubic centimeters (cc) balloon and as needed (PRN), Bedside drainage bag. Review of the resident's physician order sheet (POS), dated February 2026, showed:-An order, dated 6/17/25, for catheter care every shift;-An order, dated 1/5/26, for wound consult as needed to evaluate and treat. Review of the resident's medication administration record (MAR), dated February 2026, showed catheter care charted as provided 45 times out of 45 opportunities. Observation on 2/18/26 at 12:00 P.M., showed the resident wore an incontinence brief. A catheter bag was positioned below the bladder, hooked onto the resident's bed frame, and facing (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the door. The resident's catheter bag was not in a privacy covering. Sediment (buildup of minerals) and a brown discoloration were inside the tubing attached to the catheter. Observation on 2/19/26 at 6:48 A.M., showed the resident's catheter bag positioned below the bladder, hooked onto the resident's bed frame, and facing the door. During an interview, the Wound Nurse said there was no gauze surrounding the resident's suprapubic tube, in between the abdominal fold. The abdominal fold was infected. During an interview on 2/23/26 at 7:38 A.M., the Wound Physician said she was unaware there was an infection at the site of the suprapubic catheter, between the abdominal fold. She had prior knowledge of the resident's past issues about the suprapubic catheter leaking; however, the resident would need to be followed up by a urologist (a specialist function for the treatment and disorders of the urinary system). Observation on 2/23/26 at 7:38 A.M., showed the Director of Nursing (DON) assessed the resident's suprapubic catheter site. During an interview, the DON said the resident had a suprapubic catheter and wound to his/her coccyx (tailbone) and left hip, so there should not be an adult brief on the resident. The brief was a contraindication because the resident had wounds and a catheter. The suprapubic site looked infected and should have a dressing between the abnormal fold. During the assessment, the resident said, That hurts, when the DON lifted his/her abdominal fold to look at the site of the catheter. The DON told the wound nurse to contact the physician and get an order if the wound needed a dressing. 2. Review of Resident #14's quarterly MDS, dated [DATE], showed:-Diagnoses included cancer, high blood pressure, obstructive uropathy (blockage of urine flow), viral hepatitis, diabetes, hemiplegia (paralysis on one side), anxiety, depression;-Cognitively intact;-Cognitively intact;-Has indwelling catheter;-Impairment on one side to the lower extremity;-Uses wheelchair;-Totally dependent with personal hygiene and toileting hygiene;-Totally dependent with transfers. Review of the resident's care plan, in use during survey, showed:-Focus: Resident has an indwelling 18 French (size) catheter related to obstructive uropathy;-Goal: No signs or symptoms of urinary infection;-Intervention: The resident has 18 French (fr) indwelling Foley (a flexible, indwelling tube inserted through the urethra into the bladder to drain urine into a bag, held in place by a small, water-filled balloon). Position catheter bag and tubing below the level of the bladder and away from entrance room door;--Check tubing for kinks each shift;--Complete catheter care per orders;--Enhanced Barrier Precautions (EBP) foley in place as directed;--Indwelling catheter;--Monitor/document for pain/discomfort due to catheter. Review of the resident's POS, dated February 2026, showed:-An order, dated 1/28/26, for catheter care every shift;-An order, dated 1/28/26, to change catheter bag every month and PRN in the morning every 30 days;-No physician's order for the indwelling catheter, including the size, and no orders to change catheter tubing, or to document urine output. Review of the resident's Treatment Administration Record (TAR), dated 2/18/26 through 2/24/26, showed staff documented the completion of catheter care at 7:00 A.M. and 7:00 P.M. Observation on 2/18/26 at 11:50 A.M., showed the resident lay in bed, with the catheter hung on the left side of the bed. The catheter tube and drainage bag were below the bladder; however, there was approximately 18 inches of yellow urine that did not flow to the covered drainage bag. During an interview, the resident said he/she currently had a urinary tract infection and had issues with staff keeping him/her clean. Staff did not complete catheter care on him/her. Observation on 2/19/26 at 8:46 A.M. and 2/20/26 at 9:08 A.M., showed the resident in bed, with the catheter hung on the left side of the bed. The catheter tubing and drainage bag were below the bladder. There was no urine in the catheter tubing. During an interview on 2/25/26 at 8:00 A.M., the DON said she expected the resident to have orders for catheter use that included the size and bulb for the catheter, and orders to change the catheter and bag, and to document catheter output. The nurses are responsible for ensuring all orders are in the medical record. They would be able to see the type of catheter the resident had by visually checking the resident's catheter or the hospital record.

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	265757	A. Building B. Wing	02/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bentwood Nursing & Rehab	1501 Charbonier Road Florissant, MO 63031

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure nutritional needs were met for two of two sampled residents receiving tube feedings. The facility failed to ensure the tube feeding pump was working properly, resulting in weight loss for one resident (Resident #13), and failed to ensure one resident received his/her scheduled bolus (method of delivering formula into the stomach through a feeding tube using a syringe) feeding (Resident #8). The sample was 22. The census was 100. Review of the facility's tube feeding policy, dated 7/31/25, showed:-Policy: Residents with an order for tube feeding will be assessed and monitored by a registered dietitian to ensure nutritional needs are being met;-Procedure: Nursing will receive tube feeding order written by physician. Resident may be weighed weekly or more often as ordered by physician. Weight monitoring recommendations may be modified by registered dietitian. Review of the facility's weight variance policy, dated 1/27/26, showed:-Policy: All residents who experience significant, insidious and/or unintentional/unplanned weight loss or gains shall be assessed for nutritional status by registered dietitian. Recommendations from registered dietitian to include but not limited to adding calorie rich/preferred snacks between meals, fortification, supplements, liberalizing diet, and plan for expected weight changes. Residents receiving supplements shall be monitored for acceptance by the Dietary Manager and nursing staff.-Residents at risk for unintentional/unplanned weight variance may be monitored with weekly weights. Weights shall be reviewed by the registered dietitian for review and assessment. 1. Review of Resident's #13's medical record, showed:-Diagnoses included stroke, chronic obstructive pulmonary disease (COPD, ineffective breathing), dysphagia (impaired swallowing), alter mental statues, cognitive communication deficit (impaired communication), and diabetes. Review of the resident's weights on the facility's weight report, showed the resident weighed 188 pounds (lbs) on 1/8/26. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 1/22/26, showed:-Severe cognitive impairment;-Dependent on staff for activities of daily living (ADLs, eating, bathing, dressing and mobility);-Weight: 191 pounds (lbs.);-Weight loss: No or unknown. Review of the resident's electronic physician's order sheet (POS), showed:-An order, dated 1/31/26 for monthly weights;-An order, dated, 1/31/26, for Jevity (tube feeding formula) 1.5 (calorie amount per milliliters (mL)) at 55 mL per hour via Gastrostomy Tube (G-tube), a medical device inserted directly into the stomach to deliver nutrition and medication;-An order, dated 1/31/26 for Water flush 300 mL every 4 hours (Q4H). Review of the resident's weights on the facility's weight report, showed a weight of 186 pounds on 2/8/26. Review of the Medical Director's progress note, dated 2/12/26, showed the resident had a warning for a -7.5% weight loss. His/Her weight was charted as 186 lbs. on 2/7/26 at 12:03 P.M. Review of the resident's care plan, in use during the time of survey, showed:-Focus: Resident has a percutaneous endoscopic gastronomy tube (PEG-tube, a soft flexible feeding tube inserted through the abdomen directly into the stomach to provide long-term nutrition, hydration and medication) related to failing swallowing;-Goal: Resident will maintain adequate nutritional and hydration with stable weight;-Interventions: Monitor for tube dislodged, tube dysfunction or malfunction. Registered dietitian will evaluate quarterly and as needed (PRN), monitor calorie intake, estimate needs, and make recommendations for changes to tube feeding as needed. The resident is dependent with tube feeding and water flushes. See Medical Directors (MD) orders for current feeding orders. Observation on 2/18/26 at 8:47 A.M. and 12:16 P.M., showed the resident's Jevity 1.5 feeding pump programmed to infuse at 55 mL/hour and water flush programed to infuse at 150 mL every four hours. The sealed Jevity 1.5 formula bottled contained 1,000 mL if formula. The bottle was labeled as hung on 2/18/26 at 7:00 A.M. At 3:54 P.M., the tube feeding infused and the container with 900 mL of formula that remained. During the timeframe of 7 hours and 8 minutes, only approximately 100 ml of (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	formula infused. Observation on 2/19/26 at 8:14 A.M., showed the resident's 1,000 mL bottle of Jevity 1.5 formula set to infuse at 55 mL/hour. At 10:25 A.M., the Jevity remained with 1,000 mL of formula that remained. At 1:37 P.M., the bottle had 850 mL of formula that remained. During the timeframe of 5 hours and 23 minutes, only approximately 150 ml of formula infused. Observation on 2/20/26 at 5:39 A.M., showed the Jevity 1.5 hung at 4:30 A.M. The self-contained prefilled tube feeding formula bottle, showed the bottle contained 1,000 ml. The tube feeding pump was programmed at 55 mL/hr. At 10:58 A.M., the resident's tube feeding was disconnected. The bottle had 900 mL of formula that remained. At 11:03 A.M., LPN C said he/she needed to change the resident due to the tube feeding leaking. Staff weighted the resident with a mechanical lift scale. LPN C said the resident's weight measured 179.4 lbs. The resident was fully dressed in pants, shirt, socks, and a brief. After the resident was back in bed, LPN C took the clothing items and weighed them which totaled 3 lbs. LPN C took mechanical weight of 179.4 lbs. minus 3 lbs., for a weight of 176 lbs. At 1:32 P.M., the tube feeding container with 800 mL of formula that remained. By 2:00 P.M., the container with 750 mL of formula remained. During the timeframe of 8 hours and 21 minutes, only approximately 250 mL of formula infused. During an interview on 02/20/2026 at 2:02 P.M., the Director of Nursing (DON) said expectations were for the nurses to check the pump to ensure the resident was receiving the nutrition. The DON said she would exchange the pump immediately. On 02/23/2026 12:13 P.M., the DON said the resident was sent to the emergency room (ER) Friday night due to a hole in his/her tube. Review of the nurse's progress note on 2/20/26 at 2:22 P.M., showed the resident had tube feeding on his/her brief. Upon an assessment, the nurse located a small hole within the tube. LPN C notified the nurse practitioner (NP) and DON about the results. NP put orders in to send the resident to a local hospital for replacement. 2. Review of Resident #8's quarterly MDS, dated [DATE], showed:-Diagnoses included chronic kidney disease, type two diabetes, and muscle weakness;-Severe cognitive impairment. Review of the resident's care plan, in use at the time of the survey, showed:-Focus: Resident receives alternative nutritional intake via tube feeding;-Goal: The resident will be free of aspiration through the review date;-Interventions: Listen to lung sounds as indicated. Review of the resident's POS, dated 2/2026, showed:-An order, dated 2/9/26, enteral feed, after meals and at bedtime, Jevity 1.2 300ml per G-tube. Review of the resident's weights summary, showed:- On 01/13/2026, the resident weighed 101.9 lbs. On 02/07/2026, the resident weighed 95.2 lbs , which was a -6.58 percent weight loss. Observation on 2/18/26 at 9:33 A.M., showed the resident in bed awake. A bottle of Jevity 1.2 was on the resident's nightstand. There was 1000 mLs of formula still in the bottle. The bottle was dated 2/18/26. Observations on 2/19/26 at 6:19 A.M., showed the resident in bed awake. A bottle of Jevity 1.2 was on the resident's nightstand. The bottle was dated 2/18/26. There was 1000 mL of formula in the bottle. At 10:11 A.M., the resident was in bed asleep. The bottle of Jevity 1.2 was on the nightstand. There was 1000 mL of formula in the bottle. The bottle was dated 2/18/26. Observation on 2/20/26 at 6:36 A.M., showed the resident in bed asleep. A bottle of Jevity 1.2 was on the resident's nightstand. The bottle was dated 2/20/26. The bottle was unopen with the seal still on. Observations on 2/20/26 at 7:55 A.M., 8:25 A.M., and 9:00 A.M., showed the resident in the dining room during the breakfast meal. During an interview on 2/20/26 at 9:32 A.M., LPN A said the resident received bolus feedings of the Jevity 1.2 and eats food. He/She believed the resident only received a bolus if the resident ate under a certain amount. He/She did not know the amount. He/She said he/she had already administered the resident's morning bolus at approximately 8:20 A.M. and used a different bottle of Jevity 1.2 to administer the bolus than the bottle that was on the resident's nightstand. Review on 2/20/26 at 9:43 A.M., of the resident's February MAR, showed no documentation of the bolus being administered. During an interview on 2/20/26 at 10:28 A.M., Certified Nursing Assistant(CNA) B said LPN A did not administer a bolus feeding while the resident was in the dining room. He/She had been at the table where the resident was seated, assisting residents during breakfast. During an interview on 2/23/26 at 7:56 A.M., LPN A said bolus feedings should be administered per the physician's orders. He/She said meal intake (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should be documented for the resident if weight loss was a concern. During an interview on 2/23/26 at 8:08 A.M., the DON said bolus feeding should be administered per the physician's orders. She would expect the resident to receive his/her four scheduled bolus's. She would expect documentation of bolus feedings to be accurate. She would expect meal intake to be documented if weight loss was a concern. 271394

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview and record review, the facility failed to provide respiratory services consistent with professional standards of practice by failing to ensure oxygen tubing was stored properly, oxygen tubing was changed, and the oxygen rate was set properly for one of one sampled resident investigated for respiratory services and who was on oxygen (Resident #100). The census was 100.Review of the facility's undated oxygen administration policy showed implementation: Verify the practitioner's order for the oxygen therapy, because oxygen is considered a medication or therapy and should be prescribed. Review of the facility's oral inhalation administration policy, dated 9/2014, showed:-Policy: to allow for safe, accurate, and effective administration of medication using an oral inhaler or nebulizer (delivers medication directly to the lungs);-Procedure: when equipment is completely dry, store in a plastic bag with the resident's name and the date on it. Change equipment and tubing every seven days. Review of Resident #100's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/11/25, showed:-Diagnoses included chronic respiratory failure, depression, and diabetes;-Cognitively intact. Review of the resident's care plan, in use at the time of the survey, showed:-Focus: Resident is at risk for impaired gas exchange, shortness of breath;-Goal: Resident will demonstrate no decrease in activity tolerance or shortness of breath. Will experience ease of respiratory efforts;-Interventions: Adjust head of the bed for shortness of breath when lying flat, as needed. Assist with body positioning as needed to assist in easing respiratory effort. Administer oxygen therapy per order and monitor for response to therapy. Change oxygen equipment per policy. Administer respiratory medications as ordered. Monitor response to medications and monitor for effectiveness/side effects. Review of the resident's physician orders summary, dated 2/2026, showed:-An order dated 12/6/25, for ipratropium-albuterol solution (medication used to treat asthma and lung disease) 0.5-2.5 milligram (mg)/3 milliliter (ml) inhale every 2 hours as needed for shortness of breath or wheezing related to chronic obstructive pulmonary disease (CPD, lung disease) via nebulizer;-An order dated 12/7/25, for oxygen at 5 liters via nasal canula (NC) continuous;-An order 12/21/25, change the humidifier bottle (used to add moisture to the administered oxygen) and oxygen tubing weekly on Sunday night. Observation on 2/18/26 at 10:55 A.M., showed the resident in bed, awake. The oxygen concentrator (medical device that is used to deliver oxygen) on and set to 4 liters. The resident's NC was positioned in his/her nose. The oxygen tubing for the concentrator and nebulizer was dated 1/2/26. Observation on 2/19/26 at 7:53 A.M., showed the resident in his/her wheelchair in his/her room. The oxygen concentrator on and set to 4 liters. The nebulizer and oxygen concentrator tubing dated 1/2/26. Observation on 2/20/26 at 11:17 A.M., showed the resident awake in bed and wore an oxygen nasal cannula. The resident's nebulizer mask lay on the floor by the resident's bed. The resident's oxygen concentrator was on and set to 4 liters. During an interview on 2/23/26 at 7:56 A.M., Licensed Practical Nurse (LPN) A said night shift normally changes oxygen tubing. The nebulizer masks should be stored in a plastic bag when not in use. He/She would expect oxygen to be administered per the physician's order. During an interview on 2/23/26 at 8:08 A.M., the Director of Nursing (DON) said oxygen should be administered to residents at the rate ordered by the physician. She would expect the resident's nebulizer mask and nasal canula to be stored properly when not in use. She would expect the nebulizer mask to be in a plastic bag labeled with the resident's name. She would expect oxygen tubing and masks to be changed once a week on the night shift.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to ensure a medication error rate less than 5%. Out of 27 opportunities observed, five errors occurred, resulting in a 18.52% error rate (Residents #17 and #70). The census was 100.Review of the facility's Medication Administration policy, dated December 2017, showed:-Policy: Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so;-Procedures:-Medications are prepared only by licensed nursing, medical, pharmacy, or other personnel, authorized by state laws and regulations to prepare and administer medications;--Right resident, right drug, right dose, right route and right time, are applied for each medication being administered. A triple check of these five rights is recommended at in three steps in the process of preparation of a medication for administration;---When the medication is selected;---When the dose is removed from the container;---Just after the dose is prepared and the medication is put away;--The medication administration record (MAR) is always employed during medication administration. Prior to the administration of any medications, the medication and dosage schedule on the resident's MAR are compared with the medication label. Review of the facility's Eye Drop Administration policy, dated December 2017, showed:-Purpose: To administer ophthalmic solution or suspensions into the eye is a safe accurate, and effective manner;-Procedures:-Put on gloves;-If the eye drop is a suspension, shake well;-Remove the cap, taking care to avoid touching the dropper tip;-Tilt the resident's head slightly back;-With a gloved finger, gently pull down lower eyelid to form pouch while instructing the resident to look up. Place the other hand against the resident's forehead to steady. Hold the inverted medication bottle between the thumb and index finger, and press gently to instill prescribed number of drops into pouch near outer corner of the eye. If the resident blinks or a drop lands on the resident's cheek, repeat administration;-Instruct the resident to close eyes slowly to allow for even distribution over the surface of the eye; The resident should also refrain from blinking or squeezing eyes shut. Review of dorzolamide-timolol ophthalmic solution (medication to lower pressure in the eyes) leaflet instruction for use, revised January 2023, showed:-Apply eye drops in the following way:--Remove protective cap;--Tilt head back and look at the ceiling;--Gently pull the lower eyelid down until there is a small pocket;--Squeeze the upturned dropper bottle to release a drop into your eye;--While keeping the affected eye closed, press fingers against the inner corner of the closed eye (inner canthus), the side where the eye meets the nose and hold for about two minutes. This helps to stop the medicine from getting into the rest of the body;-- Avoid touching the dropper tip against your eye or anything else;--Replace and tighten the cap straight after use. 1. Review of Resident #17's MAR, dated February 2026, showed:-An order, dated 2/7/26, for dorzolamide-timolol ophthalmic solution 2-0.5%, instill one drop in both eyes, three times daily. Hours: 8:00 A.M., 12: 00 P.M., and 5:00 P.M.;-An order, dated 2/7/26, for Symbicort (budesonide/formoterol, an inhaler used to treat lung disease) inhalation aerosol, two puffs, twice daily. Hours: 7:00 to 10:00 A.M. and 4:00 P.M. to 7:00 P.M.;-An order, dated 2/10/25, for Yupelri oral inhaler solution (a breathing treatment used to treat lung disease) 175 micrograms (mcg)/3 milliliters (ml), give one time daily. Hours: 7:00 to 10:00 A.M. Observation on 2/20/26 at 7:47 A.M., showed Certified Medicine Technician (CMT) K and CMT I prepared the resident's medications at the medication cart. During an interview, CMT I said he/she had been a CMT for a few years but was new to the facility and CMT K was orienting him/her. CMT I gave the resident his/her oral medications and explained to the resident that he/she was going to give the resident his/her eye drops. The resident tilted his/her head back slightly. CMT I held the resident's eyes open and applied the eye drops. The resident immediately started to blink his/her eyes and CMT I gave the resident a tissue to wipe his/her eyes. CMT I did not hold or press the resident's inner canthus for two minutes after the instillation of the eye drops. CMT K and CMT I did not administer the resident's Symbicort inhaler or Yupelri oral inhaler solution breathing treatment. 2. Review of Resident #70's MAR, dated February 2026, showed:-An order, dated 10/23/25, for magnesium oxide (a supplement (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	used to treat low magnesium blood levels) 400 milligrams (mg) orally, give one time a day. Hours: 7:00 A.M. to 10:00 A.M;-An order, dated 3/23/24, for polyethylene glycol (medication used to treat constipation) 17 grams (g), give 34 g once daily. Hours: 7:00 to 10:00 A.M. Observation on 2/20/26 at 8:20 A.M., showed CMT K prepared the resident's medications. CMT K removed magnesium oxide 500 mg. out of a bottle located on the medicine cart. CMT K crushed all the resident's medication and mixed the crushed pills with pudding. CMT K mixed the polyethylene glycol with water. CMT I entered the resident's room and administered the resident his/her crushed medications and the resident started to drink the polyethene glycol mixed in water. After one sip, the resident said the water was too cold. CMT I went into the resident's bathroom and gave the resident some warm water in a cup that the resident had at his/her bedside. CMT I left the room with the cup of polyethylene glycol and water and placed it in the trash can on the medication cart. CMT K did not administer the correct ordered dose of magnesium oxide 400 mg. CMT I did not prepare the resident's polyethylene glycol with warm water as the resident requested. 3. During an interview on 2/24/26 at 9:20 A.M., CMT L said the five rights of medication administration should be followed when giving medications to the residents. The medication should be given in its entirely. CMTs are allowed to give breathing treatments and inhalers. With certain eye drops, the staff administering the eye drops should hold the resident's inner canthus for three to five seconds. He/She wasn't sure why it needed to be done that way, or which eye drops required that step. 4. During an interview on 2/24/26 at 9:30 A.M., Licensed Practical Nurse (LPN) A said the five rights of medication administration should be followed during medication administration. CMTs can give breathing treatments and inhalers. Medication should be given as ordered in its entirety. The amount of time that the resident's inner canthus needs to be held after giving eye drops is three to five minutes. LPN A wasn't sure which eye drops required that step or why it needed to be done. 5. During an interview on 2/24/26 at 10:50 A.M., the Director of Nursing (DON) said she expected staff to follow the five rights of medication administration. The resident's polyethene glycol should have been prepared with warm water and administered to the resident after the resident complained that the water was cold. She expected staff to know which eye drops required the inner canthus to be held for the recommended amount of time. CMTs can administer breathing treatments and inhalers. 2721422

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow enhanced barrier precautions during care and failed to follow acceptable infection control practices during wound care for two of two residents observed for wound care (Residents #25 and #67). In addition, staff failed to ensure one out of five residents sampled for vaccinations and health screenings had a two-step Tuberculosis (TB, infectious lung disease) Screening within the 48-72 hours post admission per facility policy (Resident #67). The sample was 22. The census was 100. Review of the Facility's Enhanced Barrier Precautions policy, dated May 2024, showed:-The Facility may expand the use of Protective Personal Equipment (PPE) & refer to the use of gowns & gloves during high-contact resident care activities that provides opportunities for transfer of Multidrug Resistant Organisms (MDROs) to hands/clothing. The use of gown & gloves for high-contact resident care activities is indicated when contact precautions do not otherwise apply, for facility residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infection/colonization;-Procedure: Dressing, transfers, providing hygiene, changing linens, changing brief or toileting, device care; central line, urinary catheter, enteral tube, tracheostomy/ventilator, and wound care: skin opening requiring a dressing. 1. Review of Resident's 25's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/16/26, showed:-Diagnoses included need for personal assistance, paraplegia (impaired motor and sensory in lower extremities), and diabetes;-Number of stage 3 pressure ulcers (full-thickness skin injury appearing as a deep, open, crater-like wound where subcutaneous fat is visible, but muscle, tendon, or bone are not exposed): three are present, but not present upon admission;-Number of stage 4 pressure ulcers (full-thickness wound extending to exposed bone, tendon, or muscle): one is present, but not present upon admission. Observation on 2/19/26 at 9:38 A.M., showed Certified Nursing Assistant (CNA) O entered the resident's room to provide care. He/She did not perform hand hygiene upon entering the resident's room and before providing care. CNA O placed gloves on, but no gown. Staff repositioned the resident. The resident had a left hip bandage with drainage soaked through the bandage. The resident's left ankle had brown and bloody drainage, and the bandage dated 2/18. During an interview on 2/19/26 at 9:38 A.M., the Wound Nurse said the left ankle dressing had serosanguinous (clear bloody) drainage. The exterior dressing was brown and dried at the left ankle. The wound was debrided (removal of dead tissue) yesterday which would increase the drainage of the wound. Observation on 2/20/26 at 6:34 A.M., showed the Assistant Director of Nurse (ADON) and Wound Nurse entered the resident's room to provide care. The ADON draped a towel over her left shoulder as she entered the resident's room. Both staff wore gloves and gowns. The ADON removed the towel from her shoulder and placed it directly under the resident's left foot. The Wound Nurse removed the soiled dressings and the foot rested directly on the towel. The Wound Nurse stepped outside and the ADON covered the resident with a blanket that had noticeable dried blood on it. The Wound Nurse returned and changed her gloves and resumed the treatment. During an interview 2/24/26 at 8:44 A.M., the ADON said she expected enhanced barrier precautions to be used for residents with wounds. The facility does not offer drapes for wound care due to the cost. She expected staff to have something clean under the resident's wound. A towel that was carried on the staff's shoulder is contaminated and should not have been used, due to the staff's hair touching the towel. 2. Review of the Facility's Tuberculosis Screening policy, dated January 2026, showed: -The community shall screen all residents for tuberculosis infection and disease. Individuals identified with active TB shall be isolated from other residents and ancillary staff until transported to an appropriate care setting that can accommodate air-borne precautions as soon as possible.-All new admissions shall have a Mantoux skin test (the test used to check for TB infection) administered within 48-72 hours of admission unless the resident has a known history of receiving the TB Vaccine (Bacille (continued on next page)

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	02/24/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Calrnette-Guerin or BCG) or know history of TB infection. The test shall be read within 48-72 hours after administration;--If the Mantoux skin test is negative, a second test shall be repeated 1-3 weeks after the first test is read, typically within 7-21 days;--If second test is negative, no repeat Mantoux testing is required, unless there is a possible known exposure to TB;-All residents shall be screened for TB symptoms annually. Review of Resident's 67's admission MDS, dated [DATE], showed:-Diagnoses included: unstageable left heel ulcer (full-thickness pressure injury where the wound base is completely covered by dead tissue (slough or eschar), making its true depth and stage impossible to determine) and Alzheimer's disease;-admitted [DATE];-Moderately impaired cognition. Review of the resident's Immunizations Report dated 2/23/2026 printed at 2:23 P.M., showed:-Step one: TB vaccine administered on 2/2/26; negative result;-Step two: Not recorded. Observation on 2/20/26 at 7:12 A.M., showed the Wound Nurse and Licensed Practical Nurse (LPN) C entered the resident's wound to provide wound care. The Wound Nurse sterilized the bedside table with a Sani wipe (medical grade anti-bacterial wipe), then lay Kleenex down on the surface as a barrier. The Wound Nurse touched the bed frame with his/her gloved hand, unfastened the resident's brief, then removed the dressing dated 2/19 from the resident's buttocks. The dressing was saturated with drainage. The Wound Nurse cleansed the wound, changed her gloves and used skin prep (barrier wipe) on the skin surrounding the wound, then waved her hand back in forth to help it air dry faster. LPN C touched the resident then reached over and handed the Wound Nurse Sterile gauze from the bedside table using his/her gloved hand. The Wound Nurse used the gauze to provide wound care. During an interview 2/20/26 at 7:12 A.M., the Wound Nurse said she waved her hand to help the air dry the skin prep. During an interview 2/20/26 at 7:12 A.M., LPN C said he/she broke the clean barrier when he/she touched the resident then handed a supply from the clean field to the Wound Nurse to use on the wound. During an interview 2/24/26 at 8:44 A.M., the ADON said she expects staff to complete glove changes after they touch something dirty and before they handle a sterile gauze to be used in a dressing change.