

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265523	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/04/2023
NAME OF PROVIDER OR SUPPLIER Parkwood Skilled Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3201 Parkwood Lane Maryland Heights, MO 63043	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>42247</p> <p>Based on interview and record review, the facility failed to ensure services provided met professional standards of practice when staff failed to do neurological checks (neuro-checks, an assessment completed by nursing staff to monitor for changes in the resident's neurological (nervous system) status) per the facility's policy for one of three residents sampled for falls (Resident #3). The sample was six. The census was 70.</p> <p>Review of the facility's Fall Management Guidelines Policy, dated 10/20/21, showed:</p> <p>-Following a resident's fall: the licensed nurse assesses the resident for injuries (including neuro checks if indicated) and provides necessary treatment; the physician and resident's representative are notified; appropriate interventions are implemented; continue ongoing assessment and documentation by licensed nurses per practice; the licensed nurse documents occurrence on the 24-hour nursing summary;</p> <p>-Procedure: Objective: record the resident's current vital signs, response to neurological assessment, current labs if applicable, identify any pertinent disease or diagnosis, any medications that could contribute to falling, history of previous falls and evidence of impaired safety judgement;</p> <p>-Ongoing assessment including neurological, pain and alert charting documentation shall occur per policy;</p> <p>-The policy failed to show how often neuro checks should be completed and for how long.</p> <p>Review of a computer generated Neuro Check Sheet, used by the facility, showed it directed staff to perform neuro checks initially, then every 15 minutes times four, then every 30 minutes times two, then every 60 minutes times two then every shift times six.</p> <p>Review of Resident #3's medical record, showed:</p> <p>-The resident was alert and orientated times three (person, place and time);</p> <p>-Diagnoses included: wound on lower leg, venous insufficiency (failure of the veins to adequately circulate the blood), atrial fibrillation (A-Fib, irregular heart rhythm) , heart failure, neuropathy (abnormality of the nervous system), chronic obstructive pulmonary disease (COPD, lung disease), high blood pressure and high cholesterol;</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Required total assistance of staff for bed mobility and transfers.</p> <p>Review of the care plan, in use at the time of the survey, showed:</p> <p>-Problem: Resident was at risk for falls related to high risk fall score, evidenced by problem with balance; 1-2 general health conditions present; Transfer: total dependence; Mobility: immobile. Onset date 8/18/23;</p> <p>-Goal: Resident safety will be maintained through next review date;</p> <p>-Interventions: Assess contributing factors related to fall history; assess medications for contributing factors; assist resident with activities of daily living (ADLs) as needed; keep call light and most frequently used personal items within reach; therapy referral as indicated; wheel chair.</p> <p>Review of the progress notes, showed:</p> <p>-On 8/19/23 at 7:05 A.M., Resident was found on floor by aide taking care of him/her. The aide had gone to check on him/her for services at 5:15 A.M. No injuries noted; the doctor and Director of Nursing (DON) were notified and the family member was called on phone. Vitals (Blood Pressure (B/P), Pulse (P), Respirations (R) and Temperature (T)) were stable;</p> <p>-On 8/19/23 at 8:51 A.M. tramadol (medication for severe pain) 50 milligram (mg) tablet was administered for pain; at 9:22 A.M., pain evaluation showed pain at 3 (based on a scale 1-10, 3 equates to noticeable pain) or less;</p> <p>-There was no other post fall documentation.</p> <p>Review of the Incident/Accident Report dated 8/19/23, showed:</p> <p>-Type of incident: fall;</p> <p>-Reported by date/time: 8/19/23 at 5:59 A.M.;</p> <p>-Witnesses: no;</p> <p>-Type of injury: no apparent injury;</p> <p>-B/P (normal 90/60 through 120/80) was 152/88, the same B/P was recorded for lying, sitting and standing;</p> <p>-P (normal 60 through 100) was 91;</p> <p>-R (normal 12 through 18) was 18;</p> <p>-T (normal 97.8 through 99.1) was 97.9;</p> <p>-Oxygen Saturation (amount of oxygen in the blood)(O2 sat 95% through 100%) was 91%;</p> <p>(continued on next page)</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Do you plan to initiate a neuro check schedule? Yes;</p> <p>-Start time? 5:45 A.M.;</p> <p>-Action taken: neuro check, Medical Doctor (MD) notified;</p> <p>-Disposition: In house observation.</p> <p>Review of the electronic medical record, showed no neuro checks were documented.</p> <p>Review of the vital signs located in the electronic medical record, dated 8/19/23, showed:</p> <p>-At 6:21 A.M., B/P 152/88, P 93, R 18, T 97.9;</p> <p>-At 6:23 A.M., B/P 165/91, P 87, R 18, T 97.8;</p> <p>-At 6:24 A.M., B/P 156/76, P 81, R 18, T 97.6;</p> <p>-At 6:26 A.M., B/P 166/78, P 77, R 18, T 97.6;</p> <p>-At 6:27 A.M., B/P 148/80, P 77, R 18, T not documented;</p> <p>-At 6:28 A.M., B/P not documented, P 77, R 18, T 97.7</p> <p>-At 8:50 A.M. pain scale of 5 (moderately strong pain) documented;</p> <p>-At 8:54 A.M., B/P 151/93 no other vital signs documented;</p> <p>-At 8:55 A.M., B/P 151/93, P 98, no other vital signs documented;</p> <p>-At 9:06 A.M., B/P 151/93, P 98, R 18, T 97.7;</p> <p>-At 9:07 A.M., B/P 149/94, P 96, R 18, T 98.1;</p> <p>-At 11:35 A.M., B/P 133/79, P 94, R 18, T 97.3;</p> <p>-No vital signs documented after 11:35 A.M.</p> <p>During an interview on 10/3/23 at 1:55 P.M., Certified Medication Technician (CMT) A said if a resident fell , he/she would stay with the resident and yell out for help. Then, he/she would make sure the resident did not have any injuries and start taking the resident's vital signs while he/she waited on the nurse to arrive.</p> <p>During an interview on 10/3/23 at 2:00 P.M., CNA B said if a resident fell , he/she would tell the nurse. The nurses and the CMTs did residents' vital signs.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/3/23 at 2:15 P.M., Nurse C said staff notified him/her if a resident fell . Then he/she assessed the resident, did vital signs and neuro checks, notified the doctor and the Power of Attorney (POA) and documented the incident in the nurse's notes and on the report sheet. Neuro checks were started immediately, then completed every 15 minutes times four, then every 30 minutes times two, then every hour times two, then every shift times 72 hours. Neuro checks were documented in the computer and the computer generated the schedule. CNAs, CMTs and nurses could do vital signs but only the nurses did the neuro checks. If a resident was on a blood thinner, Nurse C would send the resident to the hospital to be checked out.</p> <p>During an interview on 10/4/23 at 6:10 A.M., Nurse D said if a resident fell , he/she would assess the resident, check to see if the resident had an injury or pain and ensure neuro checks were in place. If the resident was ok, the resident would be assisted up. Nurse D would write up the incident report, document the incident in the nurse's notes and on the report sheet, and notify the doctor, DON and resident's responsible party. Neuro checks were completed on residents who hit their head or who had an unwitnessed fall. The nurses were responsible for doing the vital signs and the neuro checks. Neuro checks were documented in the computer and the computer generated a form. The CNA reported to him/her the resident was on the floor. He/She went into the resident's room and found the resident on the floor holding onto the table next to the bed. The resident was trying to move him/herself on the floor. The resident was alert and did not hit his/her head. The resident denied pain and had no indication of pain. Staff used the Hoyer lift (mechanical lift) to assist the resident off the floor. Nurse D said he/she started neuro checks and documented them in the computer and notified the MD, DON and the resident's family of the incident.</p> <p>During an interview on 10/4/23 at 6:30 A.M., Nurse E said if a resident fell , he/she would assess the resident, check the resident's vital signs, notify the MD, family and DON, document the incident in the nurse's notes and on the 24 hour report sheet. If the fall was unwitnessed or if the resident hit their head, he/she would also do neuro checks. Neuro checks are documented in the computer.</p> <p>During an interview on 10/4/23 at 10:40 A.M., the Director of Nursing (DON) said falls were communicated verbally shift to shift and on the 24 hour shift report. When a resident fell , the nurse would assess the resident, notify the MD and family of the incident, complete an incident report and document it in the nurse's notes. If the resident hit their head or if the fall was unwitnessed the nurse would also do neuro checks. Neuro checks were documented in the computer and the computer generated a schedule for when neuro checks were due. Neuro checks were important to make sure you didn't have any changes going on with the resident. Staff should also document in the nurse's notes every shift for 72 hours after a resident falls. When the resident fell , he/she was on the fall matt and he/she did not hit his/her head. The nurse assessed the resident and did an initial neuro check. The resident's family visited that afternoon and they did not notice a change in the resident's condition. The DON would expect for staff to follow the facility's policy and procedures.</p> <p>During an interview on 10/4/23 at 12:24 P.M., the Administrator said he would expect for staff to follow the facility's policies and procedures.</p>		