STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265523	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkwood Skilled Nursing and Rehabilitation Center	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)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to transcribe one resident's treatment orders in the medical record when the resident was readmitted to the hospital (Resident #1) and failed to accurately document completed wound treatments or treatment refusals by the resident on the Treatment Administration Record (TAR) for three residents (Residents #1, #4 and #2). The sample was 4. The census was 82.Review of the facility's Documenting/Implementing Doctors Orders policy, dated revised February 2025, showed:-Documentation: record all orders in the residents' chart. Review of the facility's Documentation policy, dated revised February 2025, showed:-Purpose: ensure resident clinical records are accurate, complete, secure, and compliant with facility requirements and professional standards;-Maintain clinical records complete, accurate, readily accessible, and systematically organized on each nursing unit;-Include essential documentation: admission assessments, diagnoses, care plans, progress notes, treatment, medications, vital signs, consents, and discharge summaries. Review of the facility's Pressure Ulcer: Prevention and Findings Reporting policy, undated, showed:-Purpose: to treat an identified pressure ulcer as soon as possible (ASAP) and initiate treatment;-If there is a need for a treatment, the charge nurse and or wound nurse, will phone the physician and implement the order as described;-The treatment will be placed on the TAR at the time the physician order is executed;-The wound nurse will confirm, and document wound and document wound care in a nurse's note;-Wound nurse will document all treatments on the TAR, just as the charge nurse would be expected to perform;-The charge nurse and wound nurse will review the resident for a change in condition and implement the appropriate skin care interventions as ordered by the physician or wound nurse practitioner. 1. Review of Resident #1's medical record, showed:-Alert and oriented times four (person, place, time and situation);-Dependent on staff for all activities of daily living (ADLs, grooming, dressing and bathing);-Diagnoses included bilateral lower extremity amputation, bilateral hand amputations and end stage renal disease (ESRD, the kidneys no longer work as they should to meet the body's needs). Review of the care plan, in use at the time of survey, showed:-Problem: resident is frequently incontinent of bowel and bladder (B & B) and is dependent with toileting hygiene. He/She requires minimal (min)/moderate (mod) assist with transfers. He/She had a Stage II pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough. May also present as an intact or open/ruptured blister) to coccyx (tailbone) at a previous admission, 6/6/25: onset;-Goal: utilize interventions to help limit risk of skin breakdown;-Interventions included: monitor for skin breakdown and report to nurse/physician/family;-Problem: resident requires min/mod assist with bed mobility and transfers. He/She is dependent with toileting hygiene related to bilateral hand amputations. He/She is frequently incontinent of B & B. He/She had a prior Stage II pressure ulcer to his/her coccyx. He/She has a surgical wound to his/her chest per nurse's notes, 6/6/25: onset;-Goal: utilize interventions to help limit risk of skin breakdown;-Interventions included:-Apply protective or barrier lotion after incontinence;-Inspect skin complete body head to toe every week and document results;-Inspect skin daily with and care and bathing, and report any changes to charge nurse;-Treatments and dressings as ordered per physician. Review of the progress notes, dated 5/26/25 through 5/31/25, showed:-On 5/26/25 at 9:21 P.M., noted open area to resident's chest area measuring 2.5 centimeters (cm) X 2 cm. No odor noted but drainage present. Hyper granulation (an overgrowth of granulation tissue that extends beyond the wound's surface, forming a raised, red, and friable mass) noted. Area cleansed with Vashe wound cleanser (used for cleansing, irrigating, moistening and debriding acute and chronic wounds) and pat dry, a small amount of mupirocin ointment (topical antibiotic) placed to a small piece of collagen and applied to wound bed. Area covered with foam dressing. Treatment to be done every other day (QOD) and as needed (PRN) for saturation;-On 5/28/25, electronically signed on 6/5/25 at 12:05 A.M., resident was referred to wound practitioner, wound blister to the chest that opened. Initial assessment was scheduled for this day. Resident was unable to be seen by wound practitioner due to outside facility appointment which conflicted with the time in which wound practitioner made rounds at the facility. Review of the TAR, dated 5/26/25 through 5/31/25, showed:-A physician order for cleanse open area to chest with Vashe wound cleanser and pat dry. Apply a small amount of mupirocin ointment to a 2 x 2 cut piece of Puracol collagen (wound dressing). Apply to wound bed and cover with foam dressing. Treatment to be done QOD and PRN for saturation. Diagnosis: unspecified open wound of unspecified front wall of thorax (chest) without penetration into thoracic cavity, start