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	10/27/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to follow its policy by not reporting an allegation of abuse for one of four sampled residents (Resident #1). Resident #1 reported an abuse allegation to staff, and the facility failed to notify the regulatory authority as required by their policy and state/federal regulations. The facility census was 84. Review of the facility's undated Abuse Policy and Procedures/Investigation Protocols showed the following:-The facility is committed to protecting residents from mistreatment, neglect, abuse and misappropriation of resident property. -This facility has adopted the guidelines of the Department of Health and Senior Services, as well as Centers for Medicare and Medicaid Services (CMS), for defining abuse, reporting, investigating and responding to appropriate parties. -The facility will ensure al alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but no later than two hours after the allegation is made, if the events that cause the allegation do not result in serious bodily injury, to the administrator of the facility and to the other officials (including to the state Survey Agency) in accordance with State Law through established procedures. Review of Resident #1's electronic medical record, showed:-An admission date of 10/15/25;-Diagnoses included morbid obesity due to excessive calories, generalized anxiety disorder and unspecified, and benign neoplasm (non-cancerous growth) of unspecified adrenal gland (produces hormones);- An initial care plan, dated 10/15/25, showed the resident is dependent on staff for mobility, requires assistance with toileting, and requires assistance with nutrition. During an interview on 10/20/25 at 8:40 A.M., the resident said on 10/18/25 around 3:00 P.M., Certified Nurse's Aide (CNA) A entered his/her room without knocking, without identifying himself/herself, and without asking to turn on the over bed lights. The lights hurt the resident's eyes, and she/he was confused and didn't understand what was happening. The resident made the comment to CNA A, you have to warn me when you're going to turn lights on, and this set (him/her) off as the CNA began yelling, You're refusing to get your ass cleaned, you don't refuse around here and used profanities. CNA A was at the resident's bedside leaning directly over him/her and continued his/her rhetoric about the resident refusing to be changed and added if I don't clean your fat ass, no one else is going to. The resident then reached for her/his bed remote to raise the head of the bed and engage in the conversation better, but CNA A snatched the bed remote out of her/his hands. The resident asked the CNA to leave for the second time. The CNA threw the remote at the resident, hitting her/him in the arm, and left the room saying he/she will smack the shit out of the resident. The resident could hear staff in the hallway asking CNA A what's going on. About 30 minutes later, Licensed Practical Nurse (LPN) C and another nursing staff entered his/her room, and LPN C said the resident will not have to work with this nurse aide again and took the resident's statement. During an interview on 10/20/25 at 11:40 A.M., assigned charge nurse LPN C said he/she received a phone call (on 10/18/25) from CNA A saying CNA B and CNA A just had an incident with the resident while trying to provide incontinence care. CNA A reported the resident refused care, called them bitches, and is saying CNA A threw the bed remote at the resident. CNA A said they left the room and called LPN C. LPN C called and reported the incident to the Administrator immediately. The resident was generally confrontational with all staff. The resident is young, dependent on staff to meet all activities of daily living and seems to be alert and oriented. During an interview on 10/20/25 at 2:00 P.M., CNA A said he/she and CNA B entered the resident's room (on 10/18/25), and CNA B waited at the door. CNA A said she/he announced their arrival and reason they were there and turned the light on. CNA A approached the resident and while reaching to pull the curtain, he/she accidently brushed up against resident's leg. CNA A said the resident responded to this with You better get out of my room bitch and then said it again in a loud voice. CNA A and CNA B left the resident's room. CNA A immediately called and reported this to the charge nurse. During an interview on 10/20/25 at 2:30 P.M., CNA B said he/she was present during the incident on Saturday (10/18/25) with the new resident (Resident #1). CNA B said the resident had been yelling at different staff all day on Saturday, saying get the f*** out of my room and things like that. CNA B said CNA A did not physically or verbally abuse or neglect the resident during the interaction on 10/18/25. The resident yelled at CNA A, saying Get out my room bitch, get out of my room bitch. CNA A did not throw a bed remote at the resident and both CNA A and CNA B left the room when told to. During an interview on 10/20/25 at 3:00 P.M., the Administrator said the facility did not report this allegation because he/she thought since they did the investigation and determined abuse did not happen, they did not need to report the allegations. The Administrator learned of the allegations from the charge nurse, who contacted him