

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  11/06/2025
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)
F 0580  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.  (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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review, the facility failed to notify one resident's responsible party regarding the resident's pressure wound (skin or soft tissue injury that develops with prolonged periods of pressure over specific areas of the body) and when the resident's pressure wound condition deteriorated. The facility also failed to notify the resident's responsible party regarding new medications ordered for the resident's behaviors (Resident # 2). The sample was five. The census was 89. Review of the facility's Change in Condition Policy, revised 8/13/25, showed:-The facility provides medical care to all the residents in this community with all their varied diagnosis and medical conditions. If a resident has a change in condition at any time during their stay at the facility, the nurse will be made aware immediately and call the physician. The nurse will provide any services that the doctor orders from the result of the change in condition. The nurse will contact the family and/or responsible party after the physician has given the orders for care of the change in condition. The nurse will document that the family and/or responsible party were contacted about the change in condition. If the family or responsible party do not answer or reply, the nurse will document that they left a message for the family or responsible party in regard to the change in condition. The facility managers have stand up meetings Monday through Friday at 9:00 A.M. to discuss all residents in the community and any change in condition along with any new services that may need to be provided in the care due to the change in condition. Review of the facility's Psychotropic (medication to treat mental disorders) Medication Policy and Procedure, undated, showed:-Responsible party actions required: -Physician and Psychiatrist: Document discussion with the resident and/or responsible party regarding the risk versus benefit of the use of the medication. Review of Resident #2's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 9/26/25, showed:-Cognitively intact;-At risk for developing pressure wounds;-One unhealed Stage One pressure wound (skin that is not broken but is red, inflamed or dark in color). Review of the resident's care plan, in use while the resident was admitted to the facility, showed:-Problem: The resident takes antidepressant medications as evidence by yelling out frequently, has concerns that people are in his/her room lying on the floor, and wanting to go home because the resident had to go to work.-Problem: The resident has a wound, abrasion, scar, or other form of breakdown present; The resident was admitted with dermatitis (inflammation of the skin) to his/her buttocks, open area to right inner thigh, and a pressure ulcer to right heel;-Interventions: Inspect the skin daily with care and bathing; Inspect skin completely head to toe every week and document results; Weekly treatment documentation to include measurement of each area of skin breakdown width, length, type tissue and drainage. Review of the resident's face sheet, undated, showed:-Primary contacts listed three family members names before the resident's name. -Diagnoses included mild protein malnutrition (inadequate nutrition), mood disorder, dementia depression, and pulmonary embolism (blood clot in the lungs). Review of the resident's progress notes, showed:-On 9/17/25 at 10:40 P.M., the resident has a dark, soft area to resident's right heel; The area was assessed and is not open at this time.-On 10/11/25 at 3:49 A.M., the dark soft area to the resident's right heel has opened. Slough (yellowish, soft, and often stringy material that forms in wounds as a result of dead or dying tissue) noted to wound bed and eschar (dark colored dead tissue) noted. The area is measuring 3 centimeters (cm) length by 7 cm wide;-No documentation the resident's responsible party was notified regarding the resident's right heel pressure wound. Review of the resident's Physician Order Sheets, dated 9/15 through 10/24/25, showed:-An order, dated 9/24/25, doxepin (medication used to treat depression) 25 milligrams (mgs) one capsule at bedtime for depression;-An order, dated, 10/6/25 stop date 10/13/25, Depakote Sprinkles (mood stabilizer)125 mg delayed release, two capsule, three times a day for mood disorder due to unknown physiological condition with depressive features;-An order, dated 10/13/25, hydroxyzine (medication used to treat anxiety) 25 mg, one tablet twice a day, for restlessness and agitation. Review of the resident's Psychiatry Nurse Practitioner (NP) notes, dated 10/4/25, showed: The resident is at the facility for a psychiatric evaluation. The resident does not know where he/she lived. As far as historical information the resident has dementia and cannot provide information. The resident has been very irritable in the evenings, unable to sleep and hard to re-direct. The resident is confused and usually is not congruent (agreement) about what the conversation is about. Medications orders attached to encounter: Depakote Sprinkles125 mg delayed release, two capsules, three times a day; doxepin 25 mgs one capsule at bedtime; hydroxyzine 25 mg one tablet twice a day. No documentation that the Psychiatrv NP notified the resident's responsible party</p>		

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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.  (continued on next page)

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review, the facility failed to ensure one resident with a pressure wound (skin or soft tissue injury that develops with prolonged periods of pressure over specific areas of the body) was assessed and monitored by performing accurate skin assessments on admission and weekly (Resident #2). The sample size was five. The census was 89. Review of the facility's Pressure Ulcer: Prevention and Findings Reporting policy, undated, showed:-Purpose: To prevent Pressure ulcers by identifying residents at risk; To treat an identified pressure ulcer as soon as possible and initiate treatment.-Policy and Procedure: The Braden scale is used as an instrument to identify skin at risk for breakdown. The Braden scale is done upon admission and quarterly. The Charge Nurse is to complete a skin assessment at least weekly, and at any time a care provider reports a change in the appearance of the skin. The Charge Nurse will complete an initial approximate measure and description of the wound in the nurse's notes. The Wound Nurse will assess the skin area of concerns and will review the physician orders for any details that might need to be described further, or need to be followed by a wound care nurse practitioner. The Wound Nurse will confirm and document wound and document wound care in a nurse's note. The Wound Nurse will document any noted additional skin changes, if any along with a detailed note outlining current condition of wound and level of progress each week. Review of Resident #2's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 9/26/25, showed:-Cognitively intact;-At risk for developing pressure wounds;-One unhealed Stage One pressure wound (skin that is not broken but is red, inflamed or dark in color). Review of the resident's care plan, in use while the resident was admitted to the facility, showed:-Problem: The resident has a wound, abrasion, scar, or other form of breakdown present; The resident was admitted with dermatitis (inflammation of the skin) to his/her buttocks, open area to right inner thigh, and a pressure ulcer to right heel;-Interventions: Inspect the skin daily with care and bathing; Inspect skin completely head to toe every week and document results; Weekly treatment documentation to include measurement of each area of skin breakdown width, length, type tissue and drainage. Review of the resident's face sheet, undated, showed his/her diagnoses included mild protein malnutrition (inadequate nutrition), mood disorder and pulmonary embolism (blood clot in the lungs). Review of the resident's Physician Order Sheets, dated September 2025, showed an order dated, 9/15/25, weekly skin assessment by Registered Nurse (RN) or Licensed Practical Nurse (LPN) every Monday night. Review of the resident's Treatment Administration Record (TAR), dated 9/15 through 10/24/25, showed:-An order dated, 9/15/25, weekly skin assessment by RN or LPN every Monday night;-On 9/15, 9/23, 9/29, 10/6, 10/13, and 10/20/25, the resident's skin assessment documented as completed. Review of the resident's progress notes, showed:-On 9/15/25, no note related to the resident's admission or skin assessment;-On 9/17/25 at 10:40 P. M., the resident has a dark, soft area to resident's right heel. The area was assessed and is not open at this time; The area was cleaned with wound cleaner and patted dry; Betadine (a type of liquid treatment to prevent infection) was applied and covered with foam dressing. The area was secured with Kerlix (a specialized dressing). Treatment to be completed every day and as needed. Heel protectors applied to both feet. Review of the resident's skin assessment data form, dated 10/6/25, showed;-Wounds: Yes;-Location of wound: Inner thigh;-Heel discoloration: No. Review of the resident's progress notes, dated 10/11/25 at 3:49 A. M., showed the dark soft area to the resident's right heel has opened. Slough (yellowish, soft, and often stringy material that forms in wounds as a result of dead or dying tissue) noted to wound bed and eschar (a layer of dead tissue) noted. The area is measuring 3 centimeters (cm) length by 7 cm wide; The area was cleaned with Vashe (wound cleaner) and patted dry; A nickel thick layer of Santyl (an ointment that removes dead tissue) applied to wound bed and covered with silver alginate (a specialized dressing) and secured with a foam dressing. The treatment is to be completed daily and as needed. Review of the medical record, showed no further completed skin assessment data forms and no further documentation of the condition of the resident's right heel pressure wound was noted. During an interview on 11/6/25 at 8:00 A.M., LPN B said on admission, a head-to-toe assessment should be completed. The weekly skin assessments are signed off on the TAR and a skin assessment data form should be completed even if there are no skin issues to report. If the resident has wounds or a skin condition, a description and the condition of the wound should be addressed on the weekly skin data assessment and in the progress notes. If a change in condition occurs related to the wound, the facility Wound Nurse is called. The Wound Nurse completes some of the treatments but not all of them. During an interview on 11/6/25 at 9:32 A.M. Nurse Manger A said the</p>		