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	06/05/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to obtain a resident's admission physician orders, including current gastrostomy tube (g-tube, a tube surgically inserted into the stomach to provide hydration, nutrition, and medications) feeding orders and a complete medication list, for one resident admitted to the facility for a respite stay (Resident #2). During the resident's stay, the facility failed to transcribe a new physician's order for added g-tube water flushes and a change to g-tube feedings from bolus (single/specified dose given all at once) to continuous. These deficient practices resulted in the resident not receiving all prescribed medications, water flushes, or continuous g-tube feedings throughout the day. The sample was 3. The census was 83.Review of the facility's Admissions policy and procedure, last reviewed 10/30/24, showed:-Purpose: The purpose of this policy and procedure is to facilitate a fluid transition of a resident into the skilled nursing facility;-Procedure:--Medical information will be requested to be reviewed by the interdisciplinary team to ensure the facility will be able to meet the needs of the potential resident;--Prior to or upon admission, Social Services (SS) will go over admission paperwork with the resident or resident representative;--A face sheet will be filled out;-Upon admission: --Nursing staff will perform admission assessment;--Nursing staff to complete the admission Checklist (a tool/form used to verify all physician admission orders, a complete list of current medications, assessments, steps, and other requirements were completed upon admission to the facility). Review of the facility's admission Checklist and Audit sheet, undated, showed:-Medication list with diagnosis;-Orders verified (clinical process where facility nurse meticulously confirms the resident's physician's admission orders/instructions are accurately transcribed into the facility's medical records and are then reviewed and verified with the facility physician at the time of admission);-Nurse signature and date. Review of the facility's Transcribe and Follow Physician Orders Accurately policy and procedure, last reviewed 04/24/25, showed:-Procedure:--There shall be a written order on a physician's order sheet for all medications, treatments, therapy, and special and modified diets, dated and signed by the physician and placed in the resident's chart;--Orders received orally or by telephone shall be taken, signed, and dated by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) acting within the scope of practice as defined by state law and is under the supervision of the physician;--Each set of orders is to be dated, and time noted when received;--All verbal and/or telephone orders are to be signed with physician's name and name of nurse receiving orders;-When taking orders for medications, include the following information:--Name;--Dosage;--Frequency;--Special instructions;-When transcribing physician's orders:--Read carefully and check with another nurse if you are unsure;--Check with physician if there are any questions;--Medication orders are placed in the electronic health record (EHR);--Dietary orders are placed in the EHR;-Orders received by physicians are to be followed as prescribed. Review of the facility's Respite admission policy, undated, showed:-The Admissions Coordinator will get the effective dates resident will be staying for the respite care stay, and coordinate with Director of Nursing (DON) any needs for care of the resident;-Purpose: The company recognizes the need for temporary caregiver relief and offers private pay respite care services when appropriate and establishes the requirements, expectations, and conditions governing private pay respite admissions (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	within the facility;-Policy Statement:--Private pay respite care is a short-term stay provided to individuals who require temporary nursing, personal care, supervision, or supportive services while their primary caregiver is unavailable or in need of relief;-Eligibility and admission Requirements:--Completion of all required admission documentation, physician orders, medication information, and emergency contact information must be provided before admission;-The facility reserves the right to:--Require additional assessments, documentation, or physician information at any time;--The community will collaborate with the Medical Director regarding any orders needed for care of the resident;-The community Medical Director will give any orders needed to care for the resident during their respite stay. Review of Resident #2's pre-admission physician orders and medication information, received 06/05/26 at 2:19 P.M. from the resident's family, Family Member C, showed:-The physician's office fax transmittal confirmation sheet result details documented as successfully sent to facility on 04/08/26 at 4:42 P.M. and completed on 04/08/26 at 4:58 P.M;-History of present illness: The resident was seen on 04/08/26 for chronic conditions, with diagnoses of dementia, stroke, difficulty swallowing (using feeding tube), neurogenic bladder (nerve damage disrupts the communication between the brain and bladder), heart attack, atrial fibrillation (irregular heart rhythm), chronic obstructive pulmonary disease (COPD, lung disease), and diabetes;-Outpatient medications, listed as e-prescribe (current, active medications), as of 04/08/26:--Fluoxetine (antidepressant) 40 milligrams (mg) by g-tube daily;--Eliquis (blood thinner) 5 mg by g-tube twice daily;--Amiodarone (used to treat heart rhythm disorders) 200 mg tablet once daily by g-tube;--Metoprolol tartrate (treats high blood pressure) 50 mg tablet, take one tablet by mouth twice daily;--Atorvastatin (lowers bad cholesterol) 80 mg tablet, take one tablet by g-tube once daily at bedtime;--Aspirin (inhibits blood clotting to help prevent heart attacks and strokes) 81 mg tablet, once daily by g-tube;--Blood glucose meter kit (measures the amount of sugar in the blood) and test strips to check blood sugars with lancets (small, sterile, disposable needles), three times daily before tube feeding;--Lantus SoloStar U-100 insulin (a pre-filled, disposable insulin pen containing a long-acting insulin), 100 unit/ml pen, syringe. Give 32 units every morning;--Novolog FlexPen U-100 Insulin (a rapid-acting insulin pen), 100 unit/ml, pen syringe (must give before tube feeding):---Give 2 units for blood sugar between 151-200;---Give 4 units for blood sugar between 201-250;---Give 6 units for blood sugar over 250;--Budesonide (potent steroid to reduce lung/respiratory inflammation) 0.5 mg/2 ml suspension for nebulization (medication is put into the nebulizer medical device that converts the liquid medication into a fine mist that is easily inhaled into the lungs). Take 4 ml (1 mg) by inhalation daily;--Xopenex (a bronchodilator/rescue inhaler) 0.63 mg/3 ml solution for nebulization. Take 3 ml by inhalation every four hours, as needed, for shortness of breath or wheezing;--[NAME] Farms Glucose Support (plant-based nutrition shake) 1.2 calories per 1 ml of fluid (250 ml per bottle). Give 320 ml (one and 1/4 cartons) bolus, via a percutaneous endoscopic gastrostomy (PEG, a medical device inserted directly through the abdominal wall into the stomach to provide a direct channel for liquid nutrition, hydration, and medications) tube, four times daily;--Tube feeding recommendations from dietitian August 2025, for [NAME] Farms Glucose Support 1.2 cartons (250 ml each), give one and 1/4 cartons, four feedings daily. Flush with 70 ml of water before and after each feeding. Review of the resident's nurse's note, dated 05/07/26 at 3:06 P.M., showed RN B documented the resident was admitted for 5-day respite care stay. The DON and charge nurse were made aware of resident's arrival. The note did not include documentation of verification of the resident's admission orders with the facility physician. Review of the resident's physician order sheet (POS) and medication administration record (MAR), dated 05/07/26 through 05/11/26, showed:-admission date 05/07/26;-An order, dated 05/07/26, for Lantus SoloStar U-100 insulin 100 unit/ml (3 ml) subcutaneous pen 22 units subcutaneous every morning;--The order for Lantus SoloStar U-100 insulin 100 unit/ml (3 ml) for 10 units less than indicated on the resident's pre-admission physician orders and medication information;-An order, dated 05/07/26, for [NAME] Farms Glucose Support 1.2 0.06 gram-1.2 kilocalorie (kcal)/ml oral liquid, 1 Misc PEG tube every six hours. [NAME] Farms Glucose (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Support 1.2 0.06 gram-1.2 kcal/ml oral liquid, Misc 1 1/4 box PEG tube every six hours; --The order for [NAME] Farms Glucose Support 1.2 did not define Misc and did not include specify the medication to be administered as bolus feeding, as indicated the resident's pre-admission physician orders and medication information;-No physician orders or documented medication administration for fluoxetine 40 mg, atorvastatin 80 mg, aspirin 81 mg, Budesonide 0.5 mg/2 ml suspension, or Xopenex 0.63 mg/3 ml solution for nebulization;-No physician order for Novolog FlexPen U-100 insulin or sliding scale insulin;-No physician orders for blood glucose meter kit and test strips or documentation of obtaining the resident's blood glucose;-No physician order for PEG tube water flushes 70 ml before and after each tube feeding, as indicated on the resident's pre-admission physician orders and medication information. Review of the resident's medical record, showed a physician's handwritten order, dated 05/08/26 (no time), for the tube feeding to be changed to 55 ml per hour, with every four-hour 100 ml water flushes. The order was signed off as transcribed by the DON, who wrote below the order to continue stock from home, and dated 05/09/26 (no time). Review of the resident's electronic POS and MAR from 05/08/26 to 05/11/26, showed no new order for the resident to have continuous gastrostomy tube feeding at 55 ml per hour, with every four-hour, 100 ml, water hydration flushes. During an interview on 06/02/26 at 1:30 P.M., LPN Unit Manager (UM) A, said they used the resident's prescription bottles, which the family brought in, and the family member's verbal instructions to write the resident's admission orders. During an interview on 06/03/26 at 12:20 P.M., RN B said he/she admitted the resident in the afternoon on 05/07/26, and he/she was not sure if there were admission orders. He/She did not recall seeing a hard chart, but there could have been one. There had to be physician orders, but he/she could not recall. Family Member C provided staff with all the resident's medications in a bag and all had pharmacy labels. RN B did not recall using the resident's prescription bottles/labels to input the medication orders into the electronic chart. His/Her practice is to compare the prescription bottles to the paper orders. Family Member C also brought in the resident's tube feeding cartons and set everything up for the tube feedings in the resident's room. RN B understood the tube feedings were bolus feedings and he/she did not see any gravity feeding bags brought in by the family member. When asked if he/she called the resident's facility physician to verify the admission orders, RN B could not recall. During an interview on 06/02/26 at 2:15 P.M., the Admissions Marketer said the resident had admission orders and they would have been written within 60 days or so of the resident's facility admission date. She would not have accepted the resident for an admission/respite stay without physician's orders. She gave the orders to the admission nurse, via placement in the resident's paper chart/hard chart. Hard charts were still used, in addition to the EHR, for new admission packet placements and for some physicians to write orders in. During an interview on 06/03/26 at 1:17 P.M., the DON said admission orders were to be verified and clarified upon admission. She audited the resident's admission orders on 05/09/26. The DON gave no details of the audit. During an interview on 06/12/26 at 12:25 P.M., the Administrator said he was out of town when the resident was admitted . Normally, their respite admissions are in hospice care, so they come to the facility with clear orders for care and medications from the hospice company. Resident #2 was not in hospice care. All the resident's physician orders should have been followed. 3012241