STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265791	A. Building B. Wing	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brooking Park	307 South Woods Mill Road Chesterfield, MO 63017

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 ensure Registered Nurse (RN) C completed and document physical and neurological assessments of Resident #1 after he/she was found unresponsive in his/her room by Certified Nursing Assistant (CNA) A. RN C went to the resident's room and found him/her sitting on the floor with his/her back leaning against his/her recliner. RN C failed to complete and document assessments of the resident after finding the resident on the floor and while waiting on emergency medical services (EMS) to arrive. Once EMS arrived, cardiopulmonary resuscitation (CPR, a lifesaving technique that's used in emergencies in which someone's breathing or heartbeat has stopped) was initiated. Three residents were sampled. The census was 62. Review of the facility Condition Change (Observing, Recording, and Reporting) policy revised on 2/2019, showed: -Policy Statement: To observe, record, and report any condition change to the attending physician so proper treatment will be implemented; -Equipment: Blood pressure cuff, stethoscope, thermometer, flashlight and pulse oximeter (measures the percentage of oxygen in the blood); -Procedure: 1. After resident falls, injuries, or changes in physical or mental condition, monitor and observe for the following: a. Lacerations; b. Swelling and discoloration; c. Convulsions; d. Headache or pain; e. Bleeding; f. Blood in body fluids; g. Personality changes; (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	7. Monitor resident's condition frequently until stable. Review of the facility's RN Charge Nurse job description, undated, showed: -Summary of Position: Responsible for the general well being of residents on the unit through the delivery of high quality services in a manner consistent with the philosophy of the facility as well as complies with applicable state, federal, and facility policies and regulations. Responsible for the management and supervision of the staff in the unit; -Essential Functions: -Direct the day-to-day functions of the CNAs per facility policy and their respective job descriptions; -Ensure that the written policies and procedures that govern the day-to-day functions of the nursing service department are followed by all nursing personnel assigned to you; -Perform administrative duties such as completing medical forms, reports, evaluations, studies, charting, care plan updates, etc., as necessary; -Chart all accidents/incidents involving the resident. Follow established procedures; -Chart nurse's notes in an informative and descriptive manner that reflects care provided to the resident, and resident's response to the care; -Perform routine charting duties as required and in accordance with our established Charting and Documentation Policies and Procedures; -In the absence of the Administrator or a Department head, the RN Charge Nurse is responsible to lead and direct all staff during an emergency or disaster in a manner consistent with established plans. Review of Resident #1's census report, located in the electronic healthcare record (EHR), showed an admission date of [DATE]. Review of the resident's Nursing Baseline Care Plan, located in the EHR, showed: -Can the resident communicate easily with staff?: Yes; -Does the resident understand the staff?: Yes; -Cognitively intact; -Discharge Planning: Wishes to return home. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's medical diagnoses, located in the EHR, showed diagnoses included chronic obstructive pulmonary disease (COPD, an ongoing lung condition caused by damage to the lungs), congestive heart failure (CHF, the heart does not pump blood efficiently), obstructive sleep apnea (sleep related breathing disorder marked by repetitive pauses in breathing), and diabetes mellitus (low/high blood sugar levels). Review of the resident's progress notes, located in the EHR, showed: -[DATE] at 6:30 A.M., and documented by RN C, showed the resident was found sitting on the floor leaning against recliner. Resident did not respond to stimuli. Called 911 at 6:32 A.M. and physician. After five minutes EMT (emergency medical technician) arrived at 6:44 A.M. and started CPR. Reported to oncoming nurse; -The RN did not document a physical assessment including vitals (temperature, pulse, respirations, blood pressure)), lung sounds, oxygen level, blood glucose level, or neurological assessment including pupil size and response to light, after the resident was found unresponsive, or ongoing assessments as RN C waited for EMS to arrive. During an interview on [DATE] at 2:00 P.M., CNA A said he/she found the resident sitting on the floor with his/her back leaning against the recliner. He/She went and told RN C who came to the resident's room and the resident did not respond. RN C shook the resident, but he/she still did not respond. RN C left the room to call 911 and CNA A remained with the resident. RN C returned to the room after calling 911 and they waited on EMS to arrive. He/She did not see RN C take vitals, listen to the resident's lungs or obtain oxygen saturation levels. RN C did not instruct CNA A to take vital signs. The resident had a snoring type breathing the whole time until EMS arrived. Review of RN C's written statement, dated [DATE], showed the resident was sitting in his/her recliner and received his/her morning medications shortly before 6:25 A.M., when CNA A came to the nurses station and informed RN C the resident was on the floor. The nurse went to the resident's room and observed the resident sitting on his/her bottom in front of the recliner with his/her legs out in front of him/her, drooling. This nurse attempted to arouse the resident by shaking his/her shoulders and calling his/her name. Resident was not aroused. RN C left the room to call 911 and doctor. CNA remained with the resident. RN C returned to the resident's room until the arrival of EMS. RN C reported the resident's condition to EMS. EMT instructed RN C to initiate CPR. Chest compressions were started by RN C. Two person rotation of CPR continued. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on [DATE] at 8:37 A.M., RN C said when he/she and CNA A went into the resident's room, the resident was sitting upright with his/her back resting against the recliner. The resident's head was slumped forward and he/she had a small amount of drool coming from his/her mouth. RN C tried to awaken the resident verbally and when the resident did not respond, he/she shook the resident. The resident remained unresponsive. RN C took the resident's pulse, it was 60 or 80. RN C did not document the pulse in the progress notes. The resident was breathing but RN C did not know how many respirations per minute. The resident's respirations sounded like snoring. RN C and CNA A did not attempt to reposition the resident. He/She left the CNA in the room while he/she went to the nurse's station to call 911. He/She returned to the resident's room after calling 911. The resident continued to have the snoring like respirations. RN C thought he/she checked the resident's pulse after returning from calling, but was not sure. RN C did not check any of the resident's vitals other than the resident's pulse. He/She did not listen to the resident's lung sounds, check the resident's oxygen or blood glucose levels, and did not check the resident's pupils. RN C should have done those things as part of an assessment and documented it in the resident's progress notes, but he/she did not. When EMS arrived, they had him/her begin chest compressions while one of the EMT's started respirations. Review of the EMS report, showed the following: -[DATE]: Call received at 6:32 A.M., at patient at 6:44 A.M.; -Upon arrival on scene entry was made through the front door of the facility. EMS was directed to the patient's room by staff. Upon contact with the patient he/she was found sitting on the floor leaning against his/her chair. Staff stated that he/she had slid out of his/her chair and was not responding appropriately. The patient presented with secretions in his/her airway, no spontaneous respirations, warm, dry and pink, no palpable pulses, and unresponsive. An ALS (advanced life support) assessment was performed. Staff stated that the patient's last known normal was five minutes prior to calling 911. The patient was moved from his/her sitting position to laying supine on the floor and CPR was initiated. Medical control at the hospital was contacted and permission to terminate efforts were granted by the hospital physician. Expired at 7:13 A.M. During an interview on [DATE] at 9:00 A.M., the Director of Nursing (DON) said he/she read RN C's progress note for the resident. The progress note offered very little as to what happened. RN C did not do any vitals at all. He/She did not do any kind of an assessment including vitals, lung sounds, oxygen saturation levels or blood glucose levels. The DON would have expected these assessments to have been completed and on-going until EMS arrived. She would have expected RN C to have documented these assessments in the resident's EHR. She expected staff to follow the facility's policies. During an interview on [DATE] at 9:21 A.M., the resident's physician, who was also the facility Medical Director, said she saw the resident the day after the resident was admitted . The resident had CHF, but was stable. She would expect RN C to have assessed the resident including vitals, lung sounds, oxygen levels and a blood glucose level. She would have expected these assessments to have been ongoing until EMS arrived and documented in the resident's EHR. She expected staff to follow the facility policies. MO00253897