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	11/04/2025

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. (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

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	11/04/2025

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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure acceptable nursing standards of practice when a resident was admitted from the hospital with a wound vacuum (wound vac, a medical device that provides light suction to a wound with high amounts of drainage to pull the excess drainage away from the skin) in place to his/her abdomen for treatment to an open surgical wound. The facility did not verify the wound vacuum treatment orders including wound vacuum dressing changes and needed supplies upon admission to the facility. As a result, the resident did not receive treatments as ordered by the hospital while at the facility. The resident discharged to the hospital on [DATE] for wound evaluation (Resident #1). The sample was 3. The census was 51.Review of the facility's Prevention and Treatment of Skin Breakdown and Other Skin Condition policy, dated 2017, showed:-Policy: properly identify and assess residents whose clinical conditions increase the risk for impaired skin integrity, to implement preventive measures, and to provide appropriate treatment modalities for wounds according to industry standards of care;-Procedure: A skin/body audit will be done upon admission and weekly during the resident's stay. If a skin concern is noted, complete a wound ID and assessment for each skin condition identified, which will auto create a wound log. Solicit appropriate physician orders;-Treatment: if the resident is admitted with a wound, the following procedure is implemented: Initiate wound care guidelines. Notify the physician and family representative. Solicit appropriate physician orders. Review of Resident #1's hospital Discharge summary, dated [DATE], showed:-Hospital diagnoses included: partial colectomy (removal of part of the colon), severe sepsis with septic shock (systemic blood toxicity) and colon perforation (burst colon);-Hospital wound care notes: Focused assessment of midline (middle) wound vacuum:--Surgery date: 9/27/25. Location: abdomen;--Procedure: re-exploration of the abdomen, partial ileostomy (a surgical procedure that creates an opening (stoma) in the abdominal wall through which waste from the small intestine (ileum) can be discharged into a bag) and negative pressure wound therapy (NPWT, wound vac);--Date wound vacuum initiated: 9/27/25;--Measurements: length 18 centimeters (cm) x width 2.6 cm x depth 1.5 cm, with a small opening proximally (near top of abdomen) and distally (near lower abdomen);--Wound base: 100 percent (%) reddened granular (new tissue growth) tissue and 100 % friable (fragile) tissue throughout wound with two small tunneled areas; --Edges: open and defined;--Drainage: creamy serosanguinous (thin white, blood tinged drainage);--Treatment/interventions: Clean wound with Vashe (antibacterial wound cleanser). Peri wound (outer edge of wound): skin barrier wipe for moisture protection. Vac drape and place Duoderm (a thin transparent material, used as a skin protectant) placed along wound edges for protection from mechanical forces and moisture protection. Foam used, medium black foam. Place two pieces of white foam, one into each tunnel at proximal and distal ends. One piece of black foam to loosely fill wound space and one piece of black foam to cushion [NAME] pad. Pressure setting: 75 (negative pressure setting) mmHG;--Instructions for dressing changes, if wound vac machine is off/fails for greater than two hours or if dressing compromised: Remove the Vac drape and sponges and reconcile the sponge counts with the most recent wound care note. Irrigate the wound gently with normal saline (NS). Lightly pack the wound with NS moistened gauze dressing (wet to dry) and secure with dry dressing. Change wet to dry dressing daily and as needed (PRN) until seen by the physician team or wound care nurse;-Plan: Vacuum changes every Monday, Wednesday and Friday. Discharge to skilled facility. Review of the resident's facility admission physician order sheet, showed:-admitted : 10/23/25;-Shower/bath: every Wednesday and Saturday;-Skin observation: every Saturday;-No wound care orders noted. Review of the resident's progress notes, showed:-On 10/23/25 at 6:20 P.M., an admission note: Arrived by hospital transport. Mental status, able to make needs and wants clearly known. Gastrointestinal: abdomen is tender. A colostomy is present with a stoma. Skin: skin is normal. (The assessment did not address the resident's abdominal surgical wound or wound vac);-On 10/26/25 at 2:05 P.M., a skilled evaluation note: Skin warm and dry, color within normal limits. Skin note: wound vacuum and colostomy area present with no signs of infection, swelling or bleeding. Review of the resident's October Treatment Administration Record (TAR), dated 10/23/25 through 10/28/25, showed no treatment wound care orders for the abdominal wound vacuum. Review of the resident's progress note, showed on 10/27/25 at 5:13 A.M., the resident and family wanted to know the schedule for the wound vac to be changed and the wound cleaned. Currently, had a wound vac to the center of the abdomen at 75 mmHG of pressure. No order located. The physician was contacted to obtain orders to verify