

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265791	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2025
NAME OF PROVIDER OR SUPPLIER Brooking Park		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>(continued on next page)</p>

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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents who required assistance with Activities of Daily Living (ADL, grooming, eating, oral hygiene) received necessary services when staff failed to provide feeding assistance to two residents (Resident #2 and Resident #10) during meals. Additionally, staff left a dinner tray in one resident's room without attempting to wake the resident up to eat and failed to check his/her mouth after eating for debris and provide oral hygiene to remove debris, as directed in his/her care plan (Resident #1). The sample was 10. The census was 53. Review of the facility's ADLs policy, reviewed/revise date 10/29/2025, showed:-Care and services will be provided for the following activities of daily living: oral care and eating to include meals and snacks;- A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition and oral hygiene. Review of the facility's Meal Supervision and Assistance policy, reviewed/revise date 10/29/25, showed:- The facility will develop and implement an individualized care plan based on the Resident Assessment Instrument (RAI) to address the resident's needs and goals, and to monitor the results of the planned interventions such as adequate supervision during meal time;-Encourage the resident to participate with his or her meal as much as possible. When indicated, provide special devices (i.e., two-handed and/or covered cups, hand holder utensils, dishes secured with suction cups, etc.) which will increase independence and participation with meals;-Continue feeding until the resident has had enough food or until the meal is finished;-If the resident wishes to eat later, or cannot eat now, communicate the resident's wishes to your supervisor and other staff members caring for the resident and set a more appropriate time for the resident to receive the meal. 1. Review of Resident #2's Electronic Medical Record (EMR), showed:-admitted [DATE];-Diagnoses included: Chronic fatigue, high blood pressure, oropharyngeal dysphagia (difficulty swallowing that occurs in the throat, involving the oral and pharyngeal (throat) phases of the swallowing process). Review of the resident's clinical admission assessment dated [DATE] at 10:22 P.M., showed the resident weighed 186.4lbs. Review of the resident's progress notes, showed on 8/4/25 at 4:11 P.M., post admission care plan meeting held this date. The resident's family, Interdisciplinary Team (IDT), activities and dietary attended. The family requested speech therapy due to swallowing/choking issues while eating. He/She needed a modified meal plan to meet his/her needs with safe eating. Review of the resident's dietary profile, dated 8/5/25, showed:-Regular diet;-Mechanical soft texture;-Regular fluids;-Small portions;-Poor appetite;-Chewing and swallowing problems;-Partial eating assistance. Review of the resident's Care Plan, in use at the time of survey, showed:-Problem: The resident had gastroesophageal reflux disease (GERD, a chronic digestive disorder where stomach acid frequently flows back into the esophagus) due to hyperacidity;-Interventions: Avoid overeating, small frequent meals, encourage resident to take his/her time eating, alternate sips of fluid with food;-No documented need for feeding assistance. Review of the resident's physician orders dated 9/5/25, showed an order for Ensure plus or house shake three times per day for weight loss. Review of the list of residents who needed to be fed, provided by the facility, showed the resident included on the list. Review of the resident's nutrition/dietary notes, showed:-On 9/16/25 at 3:49 P.M., the resident weighed 136.4lbs., which indicated a significant weight loss for one month. No diet order was in place. Resident had a history of poor appetite/food intake. He/She was started on mirtazapine (used to treat lack of appetite/weight loss) and Ensure plus three times per day. No signs/symptoms of difficulty chewing or swallowing with food. The plan included regular diet order, encourage food/liquid intake and honor food preferences;-On 10/28/25 at 5:35 P. M., the resident weighed 123.4lbs., which indicated a significant weight loss for one month. Staff reported the resident disliked the mechanical soft diet. The dietician recommended Mighty Shakes (a fortified nutritional supplement beverage. It provides extra protein and calories) between meals. The plan included encourage food/fluid intake, set up meals, considered speech therapy (ST) evaluation for diet upgrade. Review of the resident's speech therapy notes dated 11/10/25, showed the resident observed to tolerate consecutive sips of thin liquid. He/She required assistance for holding cup. Discussed strategies to increase alertness during meals. Review of the resident's Speech Therapy Recertification and Updated Plan of Treatment, dated 11/11/25, showed:-The resident tolerated mechanical soft diet and thin liquids with minimal signs/symptoms of dysphagia with feeding assistance and verbal cues to sustain attention;-Goal: The resident would sustain attention during mealtimes to complete 75 percent of meal given verbal cues as needed to increase caloric intake. At previous baseline (10/10/25) the resident required moderate assistance to remain alert during</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observation, interview and record review, the facility failed to ensure staff provided adequate supervision and assistance for one resident (Resident #1) who required a mechanical lift (allow a person to be lifted and transferred with a minimum of physical effort) and two-person assistance for transfers when one staff transferred the resident without a mechanical lift. The sample was 10. The census was 53. Review of the facility's Safe Resident Handling/Transfer Policy, dated reviewed/revised 9/25/25, showed:-Policy explanation: all residents require safe handling when transferred to prevent or minimize the risk for injury to themselves and the employees that assist them. While manual lifting techniques may be utilized dependent upon the resident's condition and mobility, the use of mechanical lifts are a safer alternative and should be used;-Compliance guidelines:--The interdisciplinary team or designee will evaluate and assess each resident's individual mobilityneeds, taking into account other factors as well, such as weight and cognitive status;--Two staff members must be utilized when transferring residents with a mechanical lift;-Staff members are expected to maintain compliance with safe handling/transfer practices. Failure to maintain compliance may lead to disciplinary action up to and including termination of employment;--Resident lifting and transferring will be performed according to the resident's individual plan of care. Review of Resident #1's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility staff, dated 10/1/25, showed:-Severe cognitive impairment;-Chair/bed-to-chair transfer: dependent (helper does all the effort. Resident does none of the effort to complete the activity. Or the assistance of two helpers is required for the resident to complete the activity);-Diagnoses included: arthritis, Alzheimer's and non-Alzheimer's dementia, depression, need for assistance with personal care and spinal stenosis (the narrowing of the spinal canal that puts pressure on the spinal cord and nerves). Review of the resident's care plan, in use at the time of survey, showed:-Need: Resident and family have requested to have an electronic monitoring device on in his/her room at all times;--Goal: The resident or Power of Attorney (POA) will verbalize understanding of the use of the device and consent to its use through the next review;--Interventions included: a sign will be placed on the door to the resident's room notifying everyone that the room has an electronic monitoring device in place; remind resident of monitoring device prior to providing care; the device needs to be in plain view.-Need: the resident has an Activities of Daily Living (ADL) self-care performance deficit Alzheimer's, confusion, dementia, limited mobility due to spinal stenosis;--Goal: Resident will maintain current level in ADL performance through next review;--Interventions included: The resident requires mechanical lift (sit to stand, assist individuals with limited mobility in transitioning from a seated to standing position) with two staff assistance for transfers. Observation of a two-minute video footage, dated 6/30/25 at 8:59 P.M., showed the resident sat in his/her wheelchair. The wheelchair was positioned parallel to the side of the bed. Staff C put the resident's gown on and lowered the bed down. Staff C asked the resident if he/she was ready. The resident replied yes. Staff C told the resident to give him/her a hug and put his/her arms around the resident. Staff C told the resident your stiff, if you're stiff you are going to make this harder for the both of us and that he/she was going to break the staff member's back. As the resident started to move, he/she was saying oh, oh, my back. Staff C said sit up or he/she would go get another person. The resident said you don't need to do that. As the resident moved forward, he/she said ouch, ouch, my back. Staff C said to come on and give him/her a hug, 1-2-3 and stood the resident up. Staff C told the resident he/she was pushing and told the resident to let that rail go, or he/she would need to put the resident back into the chair. Staff C pivoted and sat the resident on the side of the bed. Staff failed to use the mechanical lift with two-person assistance. During an interview on 11/14/25 at approximately 9:00 A.M., Certified Nurse Aide (CNA) D said he/she knew what care the residents needed through shift-to-shift report. The resident was total care for all ADLs. All lift transfers required two persons assist. During an interview on 11/14/25 at 8:30 A.M., Register Nurse (RN) E said staff knew what care the resident required through aide-to-aide verbal report. Also, they could ask the nurse if they did not know. Lift transfers require two staff. During an interview on 11/14/25 at 2:29 P.M., the Director of Nursing (DON) said staff know what care the resident needed through a verbal report done shift to shift. If the CNA did not know, they should ask the nurse. Mechanical lift transfers require two-person assistance. A bear hug is not a proper way transfer a resident. The DON and Administrator said they were not aware of the above video. During an interview on 11/14/25 at 2:29 P.M., the Administrator said he would expect for the staff to follow the facility's policy and procedures. 2607069</p>		