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	07/24/2024

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46194 Based on interview, record review, and facility policy review, the facility failed to ensure baseline care plans were completed within 48 hours of admission for 5 (Residents #178, #228, #230, #22, and #21) of 13 sampled residents. Findings included: An undated facility policy titled, Care Plan Implementation, revealed, Policy: For [NAME] Park to provide quality care and services to each resident with a consistent standard of care a baseline care plan should be completed on each resident upon admission with a comprehensive care plan to be created on or before day 21 of their stay. The policy further indicated, Procedure: 1. At the time of admission, a Baseline Care Plan will be created in [the facility's electronic medical record system] with the completion of the Clinical Admission Evaluation. The admission nurse will ensure the baseline care plan reflects the resident's condition and needs. 2. The unit manager will review and audit the admission to ensure the Baseline Care Plan is in place and make any necessary changes or updates. 1. An Admission Record indicated the facility admitted Resident #178 on 07/10/2024. According to the Admission Record, the resident had a medical history that included diagnoses of acute respiratory failure, congestive heart failure, and chronic obstructive pulmonary disease. Resident #178's medical record revealed no documented evidence a care plan had been developed. On 07/16/2024 at 10:21 AM, Minimum Data Set (MDS) Coordinator #18 stated unit managers were responsible for ensuring the baseline care plans were complete, but the facility did not currently have a unit manager. MDS Coordinator #18 confirmed there was no baseline care plan developed for Resident #178. On 07/18/2024 at 1:33 PM, the Director of Nursing stated baseline care plans should be generated within 48 hours of admission. 39438 2. An Admission Record revealed the facility admitted Resident #228 on 07/10/2024. According to the Admission Record, the resident had a medical history that included diagnoses of chronic obstructive pulmonary disease, unspecified dementia, and urinary tract infection. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #228's medical record revealed no documented evidence a care plan had been developed. On 07/17/2024 at 3:38 PM, Minimum Data Set (MDS) Coordinator #18 confirmed there was no baseline care plan developed for Resident #228. MDS Coordinator #18 stated she believed the policy for completing baseline care plans was for them to be completed within 24 to 48 hours of admission. MDS Coordinator #18 said unit managers were responsible for checking to ensure baseline care plans were completed, but the facility did not currently have a unit manager. MDS Coordinator #18 said she did not know who was responsible for checking to make sure the baseline care plans were completed, in the absence of a unit manager. On 07/18/2024 at 1:33 PM, the Director of Nursing stated baseline care plans should be generated within 48 hours of admission. 3. An Admission Record revealed the facility admitted Resident #230 on 07/10/2024. According to the Admission Record, the resident had a medical history that included diagnoses of difficulty in walking, the need for assistance with personal care, and urinary tract infection. Resident #230's medical record revealed no documented evidence a care plan had been developed. On 07/18/2024 at 1:37 PM, Registered Nurse #19 stated he completed the admission assessment for Resident #230 but did not complete a baseline care plan. On 07/18/2024 at 3:27 PM, the Director of Nursing (DON) stated that when residents were admitted to the facility, the charge nurse should start and complete baseline care plans; however, the DON said the facility did not currently have a charge nurse, so no one was checking to make sure baseline care plans were done. On 07/18/2024 at 4:17 PM, the Administrator stated baseline care plans should be completed within 48 hours of admission. 29358 4. An Admission Record indicated the facility initially admitted Resident #22 on 06/10/2024 and readmitted the resident on 07/03/2024. According to the Admission Record, the resident had a medical history that included diagnoses of acute respiratory failure, acute kidney failure, cognitive communication deficit, and heart failure. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/10/2024, revealed Resident #22 had a Brief Interview for Mental Status (BIMS) score of 5, which indicated Resident #22 had severe cognitive impairment. According to the MDS, the resident re-entered the facility from a hospital on 07/03/2024. The MDS indicated Resident #22 was dependent on staff for toileting hygiene, showering/bathing, dressing, and personal hygiene. The MDS indicated Resident #22 had an indwelling urinary catheter, a feeding tube, and received oxygen therapy. The MDS indicated Resident #22 had an unstageable pressure ulcer that was present at the time of admission. Resident #22's medical record revealed no documented evidence a care plan had been developed. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/16/2024 at 9:13 AM, MDS Coordinator #18 searched for Resident #22's baseline care plan in the facility's electronic medical record and stated there was not a baseline care plan for the resident. MDS Coordinator #18 stated the baseline care plan should have been under the care plan tab in the medical record. MDS Coordinator #18 said unit managers were responsible for checking to ensure baseline care plans were completed, but the facility had not had a unit manager for the last month. During an interview on 07/18/2024 at 1:33 PM, the Director of Nursing stated baseline care plans should be generated within 48 hours of admission. During an interview on 07/18/2024 at 4:17 PM, the Administrator stated baseline care plans should be completed within 48 hours of admission. 5. An Admission Record indicated the facility initially admitted Resident #21 on 06/08/2024 and readmitted the resident on 07/04/2024. According to the Admission Record, the resident had a medical history that included diagnoses of Stage IV pressure ulcer of the left buttock, cognitive communication deficit, glaucoma, hypertension, and dehydration. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/11/2024, revealed Resident #21 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. According to the MDS, the resident re-entered the facility from a hospital on 07/04/2024. The MDS indicated Resident #21 required supervision or touching assistance with bed mobility, bed-to-chair transfers, and walking. The MDS indicated Resident #21 required partial/moderate assistance with toileting hygiene, dressing, and personal hygiene. The MDS indicated Resident #21was frequently incontinent of urine and always continent of bowel. The MDS indicated Resident #21 and had a Stage II and a Stage IV pressure ulcer, present at the time of admission to the facility. Resident #21's medical record revealed no documented evidence a care plan had been developed. During an interview on 07/17/2024 at 12:16 PM, MDS Coordinator #18 stated nurses completed baseline care plans from the admission assessments. MDS Coordinator #18 confirmed Resident #21 did not have a baseline care plan. During an interview on 07/17/2024 at 2:39 PM, Licensed Practical Nurse (LPN) #1 stated the admitting nurse should complete the baseline care plan. LPN #1 stated the baseline care plan was generated from the admission assessment. During an interview on 07/18/2024 at 9:48 AM, the Director of Nursing (DON) stated that when a resident arrived at the facility, a nurse completed an admission assessment, and, at that time, the baseline care plan was initiated. The DON stated unit managers were responsible for checking to ensure baseline care plans were completed, but the facility had a vacancy in the unit manager position. During an interview on 07/18/2024 at 1:33 PM, the DON stated baseline care plans should be generated within 48 hours of admission. During an interview on 07/18/2024 at 4:17 PM, the Administrator stated baseline care plans should be completed within 48 hours of admission.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 43648 Based on observation, record review, and interview, the facility failed to ensure a licensed practical nurse (LPN) verified the identity of the intended resident prior to obtaining a fingerstick blood sugar, which resulted in testing of the wrong resident. This affected 1 (Resident #17) of 2 residents observed during a finger stick blood sugar checks. Findings included: During an interview on 07/17/2024 at 3:30 PM, the Quality Control (QC) and Wound Care Specialist stated staff were expected to follow physician's orders, but the facility did not have a specific policy that addressed it, because following orders was a standard of practice. An Admission Record revealed the facility admitted Resident #17 on 06/18/2024. According to the Admission Record, the resident had a medical history that included a diagnosis of quadriplegia. The Admission Record did not reflect a diagnosis of diabetes or hypoglycemia. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/25/2024, revealed Resident #17 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS did not reflect an active diagnosis of diabetes. During an observation on 07/16/2024 at 9:16 AM, Licensed Practical Nurse (LPN) #3 entered Resident #17's room and obtained a fingerstick blood sugar. During order reconciliation, it was noted Resident #17's physician's orders did not contain an order for finger stick blood sugar checks. During a phone interview on 07/18/2024 at 12:10 PM, LPN #3 stated that when she checked Resident #17's finger stick blood sugar, she had an administration record pulled up reflecting orders, but she must not have had the correct resident. During an interview on 07/17/2024 at 12:29 PM, the Director of Nursing (DON) stated LPN #3 was the charge nurse and should have verified the physician's orders prior checking Resident #17's blood sugar. During an interview on 07/19/2024 at 8:53 AM, the Administrator stated the nurse should have ensured she had the right resident before checking Resident #17' blood sugar.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 39438 Based on observation, interview, record review, facility document review, and facility policy review, the facility failed to ensure a physician's order for the use of oxygen was in place for 1 (Resident #228) of 3 residents reviewed for respiratory care. Findings included: A facility policy titled, Oxygen Administration, dated 02/2019, revealed, NOTE: You must have a physician's order to apply oxygen. Oxygen may be administered in an emergency until a physician's order can be obtained. An Admission Record revealed the facility admitted Resident #228 on 07/10/2024. According to the Admission Record, the resident had a medical history that included diagnoses of chronic obstructive pulmonary disease (COPD) and dependence on supplemental oxygen. Resident #228's Order Summary Report, listing active orders as of 07/16/2024, revealed no orders for the use of oxygen. On 07/15/2024 at 10:38 AM, Resident #228 was observed sitting in a recliner chair in their room. The resident was wearing a nasal cannula with an oxygen concentrator set at four liters per minute. On 07/16/2024 at 8:25 AM, Resident #228 was observed sitting in a recliner chair in their room. The resident was wearing a nasal cannula with an oxygen concentrator set at four liters per minute. On 07/16/2024 at 9:03 AM, Licensed Practical Nurse (LPN) #3 stated residents should have an order for the use of oxygen and confirmed Resident #228 did not have an order for oxygen. On 07/16/2024 at 9:07 AM, LPN #3 confirmed Resident #228's oxygen concentrator was set at four liters per minute. On 07/18/2024 at 3:22 PM, the Director of Nursing stated physician's orders should be in place for the use of oxygen. She stated that the charge nurse should make sure the residents had orders in place. She stated if there was no order, staff should contact the physician for an order. On 07/18/2024 at 4:20 PM, the Administrator stated residents should have an order for the use of oxygen.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43648 Based on interview, record review, and facility policy review, the facility failed to ensure medication was stored appropriately on the medication cart so that staff could administer the medication as ordered for 1 (Resident #8) of 13 sampled residents. The facility further failed to ensure ordered medication was available in the facility for administration for 1 (Resident #232) of 13 sampled residents. Findings included: A facility policy titled, Medication Administration - General Guidelines, with an effective date of 07/2021, revealed, The facility has a sufficient staff and a medication distribution system to ensure safe administration of medication without unnecessary interruptions. 1. An Admission Record indicated the facility admitted Resident #8 on 04/12/2024. According to the Admission Record, the resident had a medical history that included a diagnosis of hereditary spastic paraplegia. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/03/2024, revealed Resident #8 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Resident #8's care plan, initiated on 04/23/2024, revealed the resident had paraplegia related to a progressive neurological process. Interventions directed staff to give medications as ordered and pain management as needed (initiated 04/23/2024). Resident #8's physician's orders, revealed an order dated 07/10/2024, for gabapentin oral capsules 100 milligrams give one capsule by mouth three times a day for neuropathy pain. Resident #8's Medication Administration Record [MAR], for the timeframe 07/01/2024 to 07/31/2024, revealed staff documented a 9 on 07/10/2024 for the morning and evening dose, on 07/12/2024 for the morning dose, and on 07/13/2024 for the morning, evening and night time dose of gabapentin. The MAR revealed 9 meant Other/See Progress Notes. Resident #8's progress notes dated 07/12/2024 at 6:58 AM and 07/13/2024 at 6:50 AM, 3:49 PM, and 7:03 PM, revealed staff documented the resident did not have the gabapentin medication. The Packing Slip Proof of Delivery, dated 07/10/2024 revealed 90 capsules of gabapentin 100 milligrams were delivered to the facility on [DATE] at 6:46 PM. During an interview on 07/15/2024 at 1:41 PM, Resident #8 stated they saw their physician the week before and a new medication had been ordered, but the medication still was not in the facility. The resident stated they received the gabapentin medication because the facility pulled the medication from the emergency supply. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/16/2024 at 11:44 AM, Certified Medical Technician (CMT) #7 stated the medications arrived on 07/15/2024 but were placed behind the incorrect resident card in the medication cart. During an interview on 07/17/2024 at 10:04 AM, the Director of Nursing (DON) stated she was unaware that the mediations were unavailable or not given. She stated her expectation would be that medications were given as ordered. During an interview on 07/17/2024 at 10:14 AM, Licensed Practical Nurse (LPN) #23 stated there was not a medication card available for the weekend and she pulled from the gabapentin medication from the emergency kit and gave the medication to the resident. During an interview on 07/17/2024 at 1:14 PM, the Pharmacist stated three cards of gabapentin had been delivered to the facility on [DATE]. During an interview on 07/18/2024 at 8:18 AM, Resident #8 stated they received their gabapentin medication. During an interview on 07/18/2024 at 10:09 AM, CMT #10 stated medications were organized by resident name and room number and the bottom drawer of the medication cart was an overflow drawer. CMT #10 stated she worked evenings, at times, and when the medications arrived in the facility, the nurse signed for the medications and then the medication cards were to be placed in the drawer behind the resident room and name in the medication care; however, some nurses just tossed the cards in the bottom overflow drawer and then when staff went to administer the medications, the staff would say there were not any medications available. CMT #10 stated the facility used agency, and those staff did not look for medication cards, but documented the medication was not available. During a follow-up interview on 07/18/2024 at 11:48 AM, the DON stated she was unsure why the medications were placed in the overstock drawer. She stated Resident #8's medications were now behind their name and room number in the drawer on the medication cart. She then stated she expected medications would be accepted, signed in, counted, and returned to the medication cart for use. During an interview on 07/18/2024 at 2:04 PM, LPN #16 stated she accepted the gabapentin medication in the facility on 07/10/2024 and gave the medication to a CMT. She did know why the CMT placed the medications in the overflow drawer and not behind the resident name and room number. She stated the staff signed there were no medications; however, she checked the other day, and all three cards were in the bottom drawer. She stated nobody checked the drawer. During an interview on 07/18/2024 at 4:04 PM, the Administrator stated that when a physician ordered medications, the medication should be given as ordered. 39438 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. An Admission Record revealed the facility admitted Resident #232 on 04/19/2024. According to the Admission Record, the resident had a medical history that included diagnoses of age-related osteoporosis without current pathological fracture, type 2 diabetes mellitus with diabetic chronic kidney disease, pain, localized swelling, hyperlipidemia, gastroesophageal reflux disease without esophagitis, and essential (primary) hypertension. The Admission Record revealed Resident #232 discharged to a private home/apartment with no home health services on 05/07/2024. An admission Minimum Data Set (MDS), with an Assessment Reference Date of 04/26/2024, revealed Resident #232 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Resident #232's Order [NAME] Report, for the timeframe 04/01/2024 to 05/31/2024, revealed an order dated 04/19/2024, for hydrochlorothiazide oral tablet 25 milligrams (mg), give one tablet by mouth in the morning for diuretic; lidocaine external patch 4%, apply to skin topically in the morning every day; magnesium oxide 400 oral tablet, give one tablet by mouth in the morning; metformin hydrochloride extended release 24 hour 500 mg, give one table by mouth one time a day for diabetes; methocarbamol oral tablet 500 mg, give one tablet by mouth three times a day for muscles; omega 3 oral capsule 1200 mg, give one capsule by mouth two times a day for vitamins; Restasis ophthalmic emulsion 0.05%, instill one drop in both eyes two times a day; simvastatin oral tablet 40 mg, give one tablet by mouth in the morning for cholesterol; and telmisartan oral tablet 40 mg, give one tablet by mouth in the morning for hypertension. Resident #232's Medication Administration Record [MAR], for the timeframe 04/01/2024 to 04/30/2024, revealed staff documented a 9 on 04/20/2024 for the administration of the following medications: hydrochlorothiazide 25 mg, lidocaine external patch 4%, magnesium oxide 400, metformin hydrochloride extended release 24 hour 500 mg, omega 3 1200 mg, simvastatin 40 mg, telmisartan 40 mg, Restasis ophthalmic emulsion 0.05%, and methocarbamol oral tablet 500 mg. The MAR revealed 9 meant Other/See Progress Notes. Resident #232's progress notes dated 04/20/2024, revealed the staff were waiting for the resident's medications to be delivered from the pharmacy. In an interview on 07/18/2024 at 12:08 PM, the Pharmacist stated medications should be available when residents were admitted . The Pharmacist stated medication are delivered to the facility on ce a day and if orders were received before 5:00 PM, the medication are delivered the same day. Per the Pharmacist, if the pharmacy received the medication orders after 5:00 PMM, the medications would be delivered the next day. The Pharmacist stated the facility fazed the resident's medications to the pharmacy on 04/19/2024 at 8:00 PM, which was after the 5:00 PM, so the medications were delivered to the facility on [DATE] at 2:30 PM. In an interview on 07/18/2024 at 3:15 PM, the Director of Nursing (DON) stated medications should be delivered by 5:00 PM and if the medications could not be delivered by 5:00 PM, the staff were to call to pharmacy and request an on-call delivery, if possible. The DON stated if the medications could not be delivered, staff should remove the medication from the emergency kit. In an interview on 07/18/2024 at 4:10 PM, the Administrator stated the facility received a copy of the resident's orders and the orders should be faxed to the pharmacy so medications could be filled and obtained on time.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39438 Based on observation, interview, record review, and facility policy review, the facility failed to ensure medications were securely stored for 2 (Resident #228 and Resident #21) of 13 in-house sampled residents observed with medications at their bedside. Findings included: A facility policy titled Storage of Medications, dated 07/2021, revealed, Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. 1. An Admission Record revealed the facility admitted Resident #228 on 07/10/2024. According to the Admission Record, the resident had a medical history that included diagnoses of chronic obstructive pulmonary disease, unspecified dementia, weakness, and dependence on supplemental oxygen. Resident #228's electronic medical record revealed their admission Minimum Data Set (MDS), with an Assessment Reference Date of 07/17/2024, was still in progress. On 07/15/2024 at 10:40 AM, a small bottle of artificial tear eyedrops and hydrocortisone cream were observed on Resident #228's bedside table. On 07/15/2024 at 10:57 AM, Resident #228 stated they did not self-administer the hydrocortisone cream or eyedrops, and they were not aware the medications were at their bedside. On 07/16/2024 at 8:25 AM, a 90-count package of [NAME] wild cherry cough drops, a small bottle of artificial tear eyedrops, and hydrocortisone cream were observed on Resident #228's bedside table. Resident #228's Order Summary Report, listing active orders as of 07/16/2024, revealed the resident did not have physician's orders for artificial tears, hydrocortisone cream, or Luden's cough drops. The report revealed the resident also did not have a physician's order to store medications at their bedside. On 07/16/2024 at 8:44 AM, Certified Nursing Assistant (CNA) #25 stated she was assigned to care for Resident #288 and did not notice the medications at their bedside. CNA #25 stated there were no wandering residents on the unit where Resident #228 resided. CNA #25 stated she thought the resident's family brought in the medications and thought it was okay for the medications to be on the resident's bedside table; however, the CNA stated she did not know the procedure. On 07/16/2024 at 9:03 AM, Licensed Practical Nurse (LPN) #3 stated she made rounds that morning. She stated if she saw medications at a resident's bedside, she would put the medications away. LPN #3 stated she did not know whether Resident #228 could self-administer medications and confirmed the resident did not have physician's orders for any of the medications on their bedside table. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/18/2024 at 3:20 PM, the Director of Nursing (DON) stated residents could store medications at their bedside in a locked box, if the facility determined the resident could self-administer the medications. The DON confirmed Resident #228 did not have an order to self-administer medications or an assessment to determine if the resident could self-administer medications. On 07/18/2024 at 4:10 PM, the Administrator stated medications should not be on stored on a bedside table in residents' rooms. 29358 2. An Admission Record indicated the facility initially admitted Resident #21 on 06/08/2024 and readmitted the resident on 07/04/2024. According to the Admission Record, the resident had a medical history that included diagnoses of a Stage IV pressure ulcer of the left buttock and need for assistance with personal care. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/11/2024, revealed Resident #21 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. The MDS indicated the resident had a Stage II and a Stage IV pressure ulcer, both resent at the time of admission. According to the MDS, the resident received pressure ulcer/injury care during the assessment look-back period. Resident #21's Order Summary Report, listing active orders as of 07/16/2024, revealed orders started on 07/04/2024 to apply Triad hydrophilic wound dressing paste to the resident's coccyx and left buttock each morning and as needed for wound care. The report revealed no physician's order to store medications at the resident's bedside. During an observation on 07/15/2024 at 11:30 AM, a tube of Triad hydrophilic wound dressing paste and a medication cup that contained a white cream was observed on Resident #21's dresser. During an interview on 07/15/2024 at 11:47 AM, Licensed Practical Nurse (LPN) #2 stated she completed a dressing change for Resident #21 that morning. She stated the tube of Triad paste was in the room when she entered, so she left it there when she was finished the resident's treatment. LPN #2 stated the Triad paste should be stored in the facility's treatment cart. During an interview on 07/17/2024 at 2:16 PM, LPN #1 stated medications should be stored in a medication cart. LPN #1 stated medications could be left in residents' rooms if the resident had a physician's order to do so and the resident had been assessed to be able to self-administer medications. The LPN stated the staff should have disposed of the paste in the cup. During an interview on 07/18/2024 at 10:32 AM, the Director of Nursing (DON) stated her expectation was for the facility's policy to be followed. The DON stated all medications were to be locked up unless the resident had been assessed to self-administer their medications and had a physician's order to do so. The DON stated the Triad paste should not have been left in the resident's room, and the cup of cream should have been disposed of after use. During an interview on 07/18/2024 at 12:28 PM, the Administrator stated his expectation was for medications to be locked in the medication cart and not left in residents' rooms.

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	07/24/2024

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39438 Based on observation, interview, record review, and facility document and policy review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety. Specifically, the facility failed to ensure: 1. open food items were labeled with a description of the food item and an open or expiration date; 2. food items were not stored beyond their use-by-dates and moldy onions were discarded; 3. dishware was allowed to airdry prior to use for meal service; 4. prepared foods were stored in a manner to prevent potential cross-contamination; and 5. the food preparation area and dietary equipment were maintained in a clean and sanitary manner, and the ceiling did not drip water onto the steam table used for meal service hot holding when it rained. Findings included: 1. An undated facility policy titled, Labeling and Dating revealed, Prepared or Opened Food -All prepared or opened foods will be wrapped or covered and labeled with the following 1. The date the product was prepared or opened and put into a container 2. A description of the item in the container. An undated facility policy titled, Food Storage revealed, 6. Leftover contents of cans and prepared foods shall be stored in covered, labeled, and dated containers in refrigerators and/or freezers. On [DATE] beginning at 9:29 AM, a tour of the kitchen was conducted with the Executive Chef. At 9:30 AM, a white container with a clear sliding door was observed to be filled with a white unknown substance that appeared to be flour. The container was labeled as onions and was not dated. At 9:31 AM, a second white container with a clear sliding door was observed to be filled with 15 purple onions. The container was not dated. On [DATE] beginning at 9:34 AM, the following open items were observed in the reach-in cooler without a date: a cucumber cut in half and wrapped in plastic-wrap, a bulk container of applesauce, a container of beef base, a container of sweet pickle relish, and bulk containers of Italian dressing, [NAME] dressing, ranch dressing, coleslaw dressing, and mayonnaise. At 9:38 AM, the Executive Chef stated he was responsible for making sure open items were dated. On [DATE] at 9:42 AM, an open, pint-sized container of baking extract was observed in a drawer below the food preparation table. The container was not labeled with an open date. At 9:43 AM, open containers of vegetable oil and teriyaki sauce were observed under the food preparation table. The containers were not labeled with open dates. (continued on next page)

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	265791	A. Building B. Wing	07/24/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 9:46 AM, an opened, resealable bag of blue cheese was observed in the walk-in cooler. The bag was not dated. On [DATE] at 9:49 AM, a gallon of strawberries and a metal container of waffles were observed in the walk-in produce cooler. The items were not dated. On [DATE] beginning at 9:51 AM, the following open items were observed in the walk-in freezer, not labeled with an open date: corned beef hash in a resealable bag, beef brisket in a resealable bag, a metal container of salmon, sausage in a resealable bag, pepperoni in a resealable bag, and a bag of fries. On [DATE] at 9:56 AM, an undated container of brown sugar was observed in the food preparation area. Undated, opened bags of nacho chips and potato chips were also observed. On [DATE] beginning at 10:03 AM, the following open items were observed without dates in the dry storage area: corn meal, pecans in a resealable bag, spaghetti noodles wrapped in plastic wrap, a plastic bag of almonds, a five-pound bag of spaghetti, and a five-pound bag of egg noodles. On [DATE] at 10:06 AM, the Executive Chef stated he was responsible for dating and labeling the items in the kitchen. The Executive Chef said he had no excuse; it should have been done. On [DATE] at 8:28 AM, the Director of Dining Services (DDS) reported that all dietary staff were responsible for dating food items in the kitchen. The DDS said all food items in the walk-in cooler and reach-in cooler should be dated. The DDS further stated the Executive Chef was responsible for the dating of food items and should be checking every day to ensure items were labeled appropriately. On [DATE] at 3:28 PM, the Director of Nursing (DON) stated that as soon as food was opened, it should be labeled and dated. On [DATE] at 4:25 PM, the Administrator said the Executive Chef was responsible for dating and labeling foods. 2. An undated facility policy titled, Labeling and Dating revealed, Perishable Foods -All perishable foods will be dated upon delivery and used before their expiration date. Any food that is past its expiration date will be discarded immediately. An undated facility policy titled, Expired Foods revealed, -Make sure all foods are within the expiration date. Check all dates before using the product. If the date is expired discard the product. Make sure to let the chef know before throwing the product away. On [DATE] at 9:31 AM, a container was observed with 15 onions and what appeared to be mold stored under the food preparation table. At 9:32 AM, a container of 11 onions and what appeared to be mold was observed on top of the food preparation table. At 9:33 AM, the Executive Chef stated he needed to contact the food vendor because the onion order was delivered last Monday, and the onions were molded. The Execuitve Chef said dietary staff had already shown him the onions, but he had not discarded them. He stated he should have discarded them and that was his fault. (continued on next page)

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	265791	A. Building B. Wing	07/24/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 9:36 AM, a container of extra-hot horseradish sauce, with a use-by-date of [DATE], was observed in the reach-in cooler. On [DATE] at 9:38 AM, the Executive Chef stated he was responsible for making sure expired items were discarded. On [DATE] beginning at 9:46 AM, the following expired items were observed in the walk-in cooler: three pounds of cream cheese with an expiration date of [DATE], two containers of low-fat cottage cheese with an expiration date of [DATE], two gallons of skim milk with an expiration date of [DATE], and three gallons of whole milk with an expiration date of [DATE]. On [DATE] at 8:32 AM, the Director of Dietary Services (DDS) stated expired or moldy food items should have been thrown away. On [DATE] at 3:28 PM, the Director of Nursing (DON) stated the DDS should perform frequent monitoring and throw items away. 3. An undated facility policy titled, Dishwasher/Catcher Policy, revealed, -All pots and pans must come from the machine straight onto the drying rack. Once the pans are dry, they can then be put away on their usual spot. Under no circumstance are any pots, pans, smallwares, silverware, or place mat's [sic] to be put away wet or even damp. On [DATE] at 11:37 AM, eight bases for the residents' meal trays were observed wet. The Director of Dietary Services (DDS) used them while wet for residents' trays during the lunch meal service. At 11:38 AM, the Executive Chef stated staff pulled the lids from the dishwashing area quickly, and that was why they were still wet. On [DATE] at 8:28 AM, the DDS said dishes were supposed to air dry, but sometimes for lunch they did not get trays back until 10:45 AM, and staff had to hurry to do the dishes before the lunch meal service. On [DATE] at 3:28 PM, the Director of Nursing (DON) stated lids and bases for meal trays should not be wet when used during meal service. On [DATE] at 4:25 PM, the Administrator said dishes should be air dried before use. 4. On [DATE] at 9:42 AM, five uncovered pans of cookies, 24 on each pan, were observed on a cart next to a trash can with no lid. On [DATE] at 8:28 AM, the Director of Dietary Services (DDS) stated he did not think the uncovered pans of cookies should have been sitting next to the trash can. The DDS indicated staff should have placed parchment paper over the cookies. 5. An undated facility policy titled, Food Preparation Area revealed, It is the policy of this facility to maintain a clean, sanitary, and safe food preparation area. (continued on next page)

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	265791	A. Building B. Wing	07/24/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A facility policy titled, Cleaning Rotation, copyright 2020, revealed, Equipment and utensils will be cleaned and sanitized according to the following guidelines or manufacturer's instructions. The policy specified, 2. Items cleaned daily: included -kitchen and dining room floors and -microwave oven, and 5. Items cleaned annually: included -ceilings. On [DATE] at 9:44 AM, trash, including a potato and noodles, was observed on the floor in the area behind the cooking equipment. The Executive Chef stated the floors were normally cleaned each Sunday, but a staff member was out, and it was not done. On [DATE] at 9:50 AM, the ceiling vent outside of the walk-in cooler in the food preparation area was observed with an excessive amount of dust accumulation. The Executive Chef stated maintenance staff were responsible for cleaning the vents. On [DATE] at 9:55 AM, the microwave was observed with food debris and a rust-like substance under the microwave plate. On [DATE] at 10:01 AM, the ceiling vent near the entrance/exit door to the kitchen was observed with an excessive amount of dust. On [DATE] at 11:02 AM, water was dripping from the ceiling in the food preparation area above the steam table used for hot holding during meal service. The Executive Chef stated the water came from the ceiling every time it rained. On [DATE] at 8:28 AM, the Director of Dietary Services (DDS) stated the floors were to be cleaned every night, and a company came to power wash the floors every other month. The DDS stated the microwave needed to be cleaned every day. The DDS indicated the dietary department needed a new microwave but had not gotten one yet. The DDS said the closing servers should be cleaning the kitchen each night. The DDS further stated the ceiling was leaking due to it raining outside. He stated housekeeping and kitchen staff should clean the ceiling vents. On [DATE] at 9:02 AM, the Maintenance Manager stated the kitchen staff usually called to let them know if there were any issues in the kitchen. The Maintenance Manager said that any issues should be reported to maintenance by way of their electronic system and by word of mouth. According to the Maintenance Manager, the ceiling in the kitchen had leaked previously and was addressed and checked. The Maintenance Manager said the kitchen got steamy when it was humid out. On [DATE] at 3:28 PM, the Director of Nursing (DON) stated floors in the kitchen should be cleaned as needed, and the microwave should be put out of use until the issues were addressed or the microwave was replaced. The DON reported she was not aware of the ceiling leaking. On [DATE] at 4:25 PM, the Administrator stated the floors in the kitchen should be cleaned daily and as needed. The Administrator reported he expected the microwave to be clean. The Administrator further stated they had issues with the ceiling in the kitchen previously, and maintenance staff looked at it; however, the Administrator did not know the details.

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	265791	A. Building B. Wing	07/24/2024

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 46194 Based on interview, record review, and facility policy review, the facility failed to ensure the medical record for 1 (Resident #12) of 5 sampled residents reviewed for unnecessary medications accurately reflected the administration of medications. Specifically, staff interviews revealed oxycodone (a narcotic pain medication) that was removed from the facility's emergency medication supply was administered to Resident #12. However, Resident #12's administration record revealed no documentation indicating the medication was administered. Findings included: A facility policy titled, Medication Administration- General Guidelines, effective 07/2021, revealed section D. Documentation (including electronic) specified, 5) When PRN [as needed] medications are administered, the following documentation is provided: a. Date and time of administration, dose, route of administration (if other than oral), and, if applicable, the injection site. b. Complaints or symptoms for which the medication was given. c. Results achieved from giving the dose and the time results were noted. d. Signature or initials of person recording administration and signature or initials of person recoding effects, if different from the person administering the medication. An Admission Record indicated the facility admitted Resident #12 on 06/19/2024. According to the Admission Record, the resident had a medical history that included a diagnosis of periprosthetic fracture around an internal prosthetic right knee joint. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/26/2024, revealed Resident #12 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. The MDS revealed that in the five days prior to the assessment, the resident received scheduled pain medication and received or was offered PRN pain medication. Resident #12's care plan included a Need, initiated on 07/09/2024, that indicated the resident was receiving pain medication related to a right hip fracture, wound, and surgical site pain. Resident #12's Order Summary Report, listing active orders as of 07/17/2024, revealed an order started on 06/26/2024 for oxycodone hydrochloride 10 milligram (mg) oral tablet, one tablet by mouth every four hours PRN for pain. A StatSafe report revealed staff removed oxycodone for Resident #12 from the emergency medication supply on 07/14/2024 at 11:02 AM, 3:49 PM, and 11:11 PM. Resident #12's Treatment Administration Record (TAR) for 07/2024 revealed no documentation that indicated staff administered any PRN doses of the resident's oxycodone on 07/14/2024. (continued on next page)

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	265791	A. Building B. Wing	07/24/2024

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/18/2024 at 9:01 AM, Licensed Practical Nurse (LPN) #13 stated she worked on 07/14/2024 from 6:30 AM to 3:00 PM. LPN #13 stated staff pulled a PRN dose of the resident's oxycodone from the emergency medication supply, and she administered it on 07/14/2024 at approximately 11:00 AM to 12:00 PM. She stated the oxycodone administration should have been documented as given on the TAR; however, she reviewed the TAR and stated she had forgotten to document that the medication was given. On 07/17/2024 at 1:50 PM, LPN #27 said he worked with Resident #12 on the evening of 07/14/2024 into the morning of 07/15/2024. LPN #27 said he pulled the resident's oxycodone from the emergency medication supply and administered them to the resident. On 07/18/2024 at 1:50 PM, the Director of Nursing (DON) stated she expected staff to document on the TAR when resident's pain medications were administered.

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	265791	A. Building B. Wing	07/24/2024

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 46194 Based on observation, interview, record review, and facility policy review, the facility failed to ensure enhanced barrier precautions (EBP) were implemented for 3 (Resident #17, #21, and #22) of 3 residents reviewed for EBP and failed to ensure respiratory equipment was stored in a manner to decrease risk of infection for 3 (Resident #22, #228, and #230) of 3 residents reviewed for respiratory care. The facility also failed to follow their infection control policy when staff failed to complete a two step and the annual one step of the employee tuberculosis (TB, a potentially serious infectious bacterial disease that mainly affects the lungs) screening tests in a timely manner for a total of seven employees. The census was 100 with 69 in certified beds. Findings included: A facility policy titled, Enhanced Barrier Precautions Policy, dated 04/2024, indicated, It is the policy of this facility that Enhanced Barrier Precautions, in addition to Standard and Contact Precautions will be implemented during high-contact resident care activities when caring for residents that have an increased risk for acquiring a multidrug-resistant organism (MDRO) such as a resident with wounds, indwelling medical devices or residents with infection or colonization with an MDRO. The policy also indicated, Enhanced Barrier Precautions require gown and glove use for residents with a novel or targeted MDRO or any resident with a wound or indwelling medical device during specific high-contact resident care activities. The policy indicated, The purpose of Enhanced Barrier Precautions is to prevent opportunities for transfer of MDROs to employee's hands or clothing during cares, beyond situations in which staff anticipate exposure to blood or body fluids. High-Contact Resident Care Activities include: -Dressing -Bathing/showering -Transferring -Providing hygiene -Changing linens -Changing briefs or assisting with toileting -Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator -Wound care: any skin opening requiring a dressing. The policy also indicated, 4. Post clear signage on the door/wall outside resident room a. Type of precautions i. Contact ii. Droplet iii. Airborne iv. Enhanced Barrier Precautions The policy revealed the facility would 5. Provide isolation cart with Personal Protective Equipment immediately outside resident room. (continued on next page)

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	265791	A. Building B. Wing	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A facility policy titled, Oxygen Administration, reviewed 02/2019, indicated, Each oxygen closet is also provided with zip lock bags hanging on hooks which contain mask, nasal cannula, airway and connecting tubing. The policy revealed staff should Label tubing, cannula, mask, and humidifier bottle (humidifier bottle may be omitted on oxygen concentrator unless room are is [sic] excessively dry) with the date applied. The policy indicated staff should, i. Change tubing, cannula, and humidifier bottle weekly. On 07/19/2024 at 2:47 PM, the Director of Nursing (DON) stated the facility did not have a policy that addressed urinary catheter maintenance related to infection control. 1. An Admission Record revealed the facility admitted Resident #17 on 06/18/2024. According to the Admission Record, the resident had a medical history that included diagnoses of quadriplegia, stage four pressure ulcer of the sacral region, local infection of the skin and subcutaneous tissue, extended spectrum beta lactamase (ESBL) resistance, unstageable pressure ulcer of the right heel, urinary tract infection, enterococcus as the cause of diseases, Escherichia coli (a type of bacteria, E. coli) as the cause of disease, proteus (a type of bacteria) as the cause of disease, colostomy status, presence of urogenital implants, and resistance to multiple antibiotics. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/25/2024, revealed Resident #17 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS revealed the resident had an indwelling urinary catheter, an ostomy, a Stage IV pressure ulcer, and two unstageable pressure ulcers. The MDS also revealed the resident had a MRDO, a urinary tract infection in the last 30 days, and a wound infection. Resident #17's Order Summary Report, listing active orders as of 07/18/2024, revealed an order started on 06/19/2024 for EBP. Resident #17's Treatment Administration Record (TAR) for 07/2024 revealed staff documented daily on each shift that EBP were provided from 07/01/2024 through 07/16/2024. During an observation on 07/15/24 at 3:27 PM, there was no signage for EBP at Resident #17's room. There was a personal protective equipment (PPE) storage cart observed hanging on the resident's door; however, there were no gowns in the cart. During an observation on 07/16/2024 at 9:16 AM, Licensed Practical Nurse (LPN) #3 donned gloves and performed a finger stick blood sugar on Resident #17. LPN #3 did not wear a gown during the observation. During an observation on 07/16/2024 at 9:54 AM, Certified Nursing Assistant (CNA) #8 repositioned Resident #17 in bed by reaching around the resident and moving pillows. CNA #8 did not wear gloves or a gown. On 07/16/2024 at 2:22 PM, CNA #8 said if a resident was on EBP, a nurse would let her know and there would be a yellow sign for EBP on the resident's door. CNA #8 said if a resident was on EBP, staff should wear a gown and gloves. CNA #8 said she was not aware of any residents currently on EBP. (continued on next page)

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	265791	A. Building B. Wing	07/24/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/16/2024 at 3:07 PM, LPN #3 said residents with wounds or an indwelling catheter required EBP. LPN #3 said if a resident was on EBP, there should be a sign on the door, and staff should use a gown and gloves for patient care. LPN #3 said there were currently no rooms with signs that indicated any residents required EBP. On 07/17/2024 at 1:41 PM, the Director of Nursing (DON) stated she expected staff to wear a gown and gloves for close contact care for residents with orders for EBP. 29358 2. An Admission Record indicated the facility initially admitted Resident #21 on 06/08/2024 and readmitted the resident on 07/04/2024. According to the Admission Record, the resident had a medical history that included diagnoses of Stage IV pressure ulcer to the left buttock, local infection of the skin and subcutaneous tissue, cellulitis of the buttock, osteolysis (resorption of bone) at an unspecified site, and streptococcus and enterococcus as the cause of diseases. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/11/2024, revealed Resident #21 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. The MDS indicated the resident required partial/moderate assistance with toileting and was frequently incontinent of urine. The MDS revealed the resident had a Stage II and a Stage IV pressure ulcer, which were present at the time of admission, and the resident had received an antibiotic medication during the assessment look-back period. Resident #21's Order Summary Report, listing active orders as of 07/16/2023, contained an order, started on 07/04/2024, for EBP. The order indicated that to reduce transmission of multi-drug resistant organisms, gown and glove usage was required during high contact care activities. During an observation on 07/15/2024 at 11:36 AM, there was no EBP signage or personal protective equipment (PPE) at Resident #21's room door. During an observation on 07/16/2024 at 7:21 AM, Certified Nursing Assistant (CNA) #25 performed incontinence care for Resident #21. CNA #25 donned gloves but did not don a gown. During the observation of care, the resident was observed with a wound on their upper left sacrum that was covered with a clear bandage, and a bandage was also observed near the resident's coccyx. During an interview on 07/16/2024 at 2:37 PM, CNA #25 stated nurses would let CNAs know if residents required EBP. The CNA stated there would also be a yellow sign on the side of the door indicating EBP were needed, and PPE would be stored on the door or at the side of door. The CNA stated if a resident required EBP, the staff would wear a gown, gloves, and a mask. According to CNA #25, the facility did not currently have any residents that required EBP and stated a gown was not required for Resident #21. CNA #25 stated a gown was only required if an infection was present or if there was a sign on the resident's door. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Brooking Park	307 South Woods Mill Road Chesterfield, MO 63017

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/18/2024 at 10:49 AM, the Director of Nursing (DON) stated if a resident had an external device, wound, indwelling urinary catheter, feeding tube, or was colonized with a MDRO, EBP were required. The DON stated if a resident required EBP, the staff should wear gloves and a gown while assisting the resident with dressing, bathing, showering, transferring, and changing linens and briefs. The DON stated the facility used yellow magnets outside residents' doors to indicate when EBP was required. She stated the information should also be given during report, and PPE should be on the residents' door or in a three-drawer cabinet by their door. The DON stated her expectation was for the staff to follow the EBP policy. During an interview on 07/18/2024 at 12:35 PM, the Administrator stated if a resident had a catheter, feeding tube, or wounds, EBP were required. The Administrator stated a yellow magnet for signage and PPE should be in place. The Administrator stated if a resident had a condition that required EBP, staff should wear a gown and gloves when providing care. The Administrator stated his expectation was for EBP to be implemented when required. 3. An Admission Record indicated the facility initially admitted Resident #22 on 06/10/2024 and readmitted the resident on 07/03/2024. According to the Admission Record, the resident had a medical history that included diagnoses of acute respiratory failure with hypoxia, pneumonia, gastrostomy status (feeding tube), chronic obstructive pulmonary disease (COPD), retention of urine, presence of urogenital implants, asthma, and acute kidney failure. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/10/2024, revealed Resident #22 had a Brief Interview for Mental Status (BIMS) score of 5, which indicated the resident had severe cognitive impairment. The MDS indicated the resident was dependent on staff for activities of daily living (ADLs). The MDS indicated the resident had an indwelling urinary catheter, a feeding tube, and an unstageable deep tissue injury that was present at the time of admission. The MDS also indicated the resident received oxygen. A. Resident #22's Order Summary Report, listing active orders as of 07/16/2024, contained an order, started on 07/05/2024, for Jevity 1.5 (tube feeding formula) to run at 60 ml per hour until the pharmacy provided Osmolite 1.2 enteral feed. The order report also contained order started 07/07/2024 for catheter care every shift for an indwelling urinary catheter, and an order started on 07/12/2024 to apply betadine and a dry dressing daily to bilateral heel wounds. The Order Summary Report did not reflect an order for EBP, despite the resident having wounds and indwelling medical devices. During an observation on 07/15/2024 at 10:28 AM, Resident #22 was in bed with continuous tube feeding infusing and an indwelling urinary catheter in place. The observation revealed the door to the resident's room had a hanging storage compartment that contained a box of gloves but no other personal protective equipment (PPE). There was no signage on the door indicating the resident needed EBP. During an observation on 07/16/2024 at 9:37 AM, Certified Nursing Assistant (CNA) #25 provided mouth care for Resident #22 with a disposable mouth swab. CNA #25 wiped the resident's face with a wet cloth, assisted the resident with their top dentures, and applied lip balm to the resident. During the observation, CNA #25 wore gloves but did not wear a gown. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/16/2024 at 2:37 PM, CNA #25 stated nurses would let CNAs know if residents required EBP. The CNA stated there would be a yellow sign on the side of the door indicating EBP were needed, and PPE would be stored on the door or at the side of door. The CNA stated if a resident required EBP, the staff would wear a gown, gloves, and a mask. According to CNA #25, the facility did not currently have any residents that required EBP and stated a gown was not required for Resident #22. CNA #25 stated a gown was only required if an infection was present or if there was a sign on the resident's door. During an observation on 07/16/2024 at 10:04 AM, Licensed Practical Nurse (LPN) #2 and LPN #3 washed their hands and donned gloves prior to administering medications to Resident #22 via their feeding tube. LPN #2 and LPN #3 did not wear gowns while administering the medications. During an interview on 07/16/2024 at 2:59 PM, LPN #2 stated if EBP were required there would be a sign on the resident's door and a PPE holder. LPN #2 further stated it was communicated during shift-change report if a resident was on EBP, and she would notify the CNAs about the precautions. Per LPN #2, residents with an infection required EBP, and if there was no infection, EBP was not required. During an interview on 07/16/2024 at 3:07 PM, LPN #3 stated EBP was required for residents who had wounds, urinary catheters, or feeding tubes. LPN #3 stated information related to EBP should be passed on during report at shift change. LPN #3 stated she did not know which residents required EBP because nothing had been mentioned in report and there were no signs on any residents' doors. According to LPN #3, residents who required EBP should have PPE available and signage on their door. LPN #3 further stated that thinking back, she should have worn a gown when working with Resident #22's tube feeding. During an interview on 07/18/2024 at 10:49 AM, the Director of Nursing (DON) stated if a resident had an external device, wound, indwelling urinary catheter, feeding tube, or was colonized with a MDRO, EBP were required. The DON stated if a resident required EBP, the staff should wear gloves and a gown while assisting the resident with dressing, bathing, showering, transferring, and changing linens and briefs. The DON stated the facility used yellow magnets outside residents' doors to indicate when EBP was required. She stated the information should also be given during report, and PPE should be on the residents' door or in a three-drawer cabinet by their door. The DON stated her expectation was for the staff to follow the EBP policy. During an interview on 07/18/2024 at 12:35 PM, the Administrator stated if a resident had a catheter, feeding tube, or wounds, EBP were required. The Administrator stated a yellow magnet for signage and PPE should be in place. The Administrator stated if a resident had a condition that required EBP, staff should wear a gown and gloves when providing care. The Administrator stated his expectation was for EBP to be implemented when required. B. Resident #22's Order Summary Report, listing active orders as of 07/16/2024, contained an order, started on 07/04/2024, for oxygen (O2) at 2 liters per minute (lpm) via nasal cannula to be administered overnight and as needed (PRN). The Order Summary Report also revealed an order started on 07/03/2024 for ipratropium albuterol inhalation solution to be inhaled orally three times a day for COPD and every six hours as needed for shortness of breath. The Order Summary Report did not reflect orders to change the resident's O2 or nebulizer tubing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 07/15/2024 at 11:24 AM, Resident #22's O2 tank was at the bedside and was not in use. The O2 tubing was observed wrapped around the resident's grab bar on their bed, not in a bag or covered. A nebulizer mask was observed on the resident's bedside table, uncovered. The O2 tubing, humidifier bottle, and nebulizer mask were not dated. During an observation on 07/16/2024 at 7:15 AM, Resident #22 was in bed receiving O2 via nasal cannula at 2 lpm. The oxygen nasal cannula tubing was undated, and the resident's nebulizer mask was on the bedside table uncovered. During an observation on 07/16/2024 at 10:04 AM, Resident #22's O2 tubing was coiled and lying on top of the O2 concentrator, and the resident's nebulizer mask was on their bedside table. Both the O2 tubing and nebulizer mask were uncovered. During an interview on 07/16/2024 at 10:36 AM, LPN #3 stated O2 tubing, and the nebulizer mask should be changed routinely and dated. She stated the nebulizer mask should be placed in a bag when not in use. LPN #3 confirmed Resident #22's O2 tubing was not dated, and their nebulizer mask was not in a bag or dated. During an interview on 07/17/2024 at 2:05 PM, LPN #1 stated night shift staff changed O2 tubing, and the tubing should be stored in a bag and dated. During an interview on 07/18/2024 at 9:36 AM, the DON stated there should be orders in place to change O2 tubing and nebulizer masks and tubing weekly. The DON stated O2 nasal cannulas and tubing and nebulizer masks should be kept bagged when not in use. The DON stated her expectation was for the staff to keep equipment clean and to follow the facility's policies. During an interview on 07/18/2024 at 12:13 PM, the Administrator stated staff should change out O2 tubing and masks, tubing should be coiled and off the floor, and the facility's policy should be followed. The Administrator further stated he expected nebulizer masks to be kept enclosed or covered and changed routinely. 39438 4. An Admission Record revealed the facility admitted Resident #228 on 07/10/2024. According to the Admission Record, the resident had a medical history that included diagnoses of chronic obstructive pulmonary disease and dependence on supplemental oxygen (O2). Resident #228's Order Summary Report, listing active orders as of 07/16/2024, revealed no orders related to the resident's use of O2. On 07/15/2024 at 10:38 AM, Resident #228 was observed sitting in a recliner chair in their room. The resident was wearing a nasal cannula with an O2 concentrator set at four liters per minute. The nasal cannula was not dated. On 07/16/2024 at 8:44 AM, Certified Nursing Assistant (CNA) #25 stated nurses were responsible for dating and labeling O2 supplies. On 07/16/2024 at 9:07 AM, Licensed Practical Nurse (LPN) #3 said O2 tubing should be dated. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/17/2024 at 2:05 PM, LPN #1 stated night shift staff changed O2 tubing, and the tubing should be dated. During an interview on 07/18/2024 at 9:36 AM, the DON stated there should be orders in place to change O2 tubing weekly. The DON stated her expectation was for the staff to keep equipment clean and to follow the facility's policies. During an interview on 07/18/2024 at 12:13 PM, the Administrator stated staff should change out O2 tubing, and the facility's policy should be followed. 5. On 07/19/2024 at 2:43 PM, an interview with the Director of Nursing (DON) revealed the facility did not have a policy related to the use of a bilevel positive airway pressure (BiPAP) machines. An Admission Record revealed the facility admitted Resident #230 on 07/10/2024. According to the Admission Record, the resident had a medical history that included diagnoses of acute respiratory failure with hypoxia, pneumonia, chronic obstructive pulmonary disease, and klebsiella pneumoniae as the cause of diseases classified elsewhere. On 07/15/2024 at 1:59 PM, a BiPAP mask and machine were observed on Resident #230's bedside table. The mask was not stored in a bag and was not dated. On 07/16/2024 at 9:33 AM, Resident #230's BIPAP mask was observed not stored in a bag. On 07/18/2024 at 9:57 AM, Licensed Practical Nurse (LPN) #13 stated Resident #230's mask came from their home, and the resident maintained it themselves. On 07/18/2024 at 3:22 PM, the Director of Nursing (DON) stated there should have been a protective bag to use for storage of Resident #230's BiPAP face mask. On 07/18/2024 at 4:17 PM, the Administrator stated there should be a bag to use for storage of BiPAP equipment. The Administrator said the mask should not be stored uncovered on a bedside table. According to the Administrator, nurse managers were supposed to make sure equipment was stored appropriately. 30687 6. Review of the facility's TB Policy dated 12/2010, showed the following: -Policy Statement: To prevent, identify and treat employees and volunteers with suspected or confirmed cases of tuberculosis; -Procedure: 1. All employees and volunteers of eight or more hours per month and employee to long term care who do not have documentation of a previously positive skin test reaction or history of adequate treatment of TB infection or disease will receive a Mantoux two-step test and will receive the first step prior to resident contact; (continued on next page)

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