STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24122	A. BUILDING: _____ B. WING _____	C 06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARC PROVENCE	605 COEUR DE VILLE DRIVE SAINT LOUIS, MO 63141

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A2010	19 CSR 30-85.022(6) Oxygen Storage Oxygen storage shall be in accordance with NFPA 99, 1999 edition. Facilities shall use permanent racks or fasteners to prevent accidental damage or dislocation of oxygen cylinders. Safety caps shall remain intact except where a cylinder is in actual use or where the regulator has been attached and the cylinder is ready for use. Individual oxygen cylinders in use or with an attached regulator shall be supported by cylinder collars or by stable cylinder carts. IM/I This regulation is not met as evidenced by: Class II* Based on observation, interview and record review, the facility failed to maintain oxygen storage in compliance with NFPA 99 (1999) requirements. This had the potential to affect all staff and residents in two of sixteen smoke compartments. The facility had census of 115 residents at the time of the licensure inspection. Review of the facility's Oxygen Storage policy, last review date of 08/2025, showed: -The facility must adhere to Missouri Code of State Regulations (19 CSR 30-85.032), which mandates compliance with the National Fire Protection Association (NFPA 99) guidelines for all oxygen storage and systems. The policy requires strict adherence to fire safety, proper ventilation, cylinder securing and segregation of equipment; -Storage Procedures: -Segregation of full and empty tanks: Full and partially full cylinders must be separated from empty tanks to avoid confusion during emergencies. Empty cylinders must be clearly labeled or placed in designated, marked racks; -Building and Signage Standards:	A2010		

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A2010	Continued From page 1 -Signage: Storage doors and areas must feature conspicuous warning signs indicting oxygen is in used and prohibiting smoking, visible from at least 5 feet away; -Staff Policies and Compliance: -Monitoring: The facility designates the Medical Records Coordinator to regularly monitor storage rooms to ensure cylinders are secured and regulations are strictly followed. 1. Observations during the fire safety tour on 06/15/26 at 1:30 P.M. and on 06/16/26 at 11:05 A.M., of the oxygen storage closet on Rose Garden, across from the resident common area and nearest the medication room, showed signage on the left side of the closet, in a clear paper sleeve, at approximately waist high, clamped onto the metal green rail of oxygen cart denoting "full," another clear sleeve, at approximately waist high, clamped onto the silver metal bar on the right side in back of the oxygen cart denoting "empty." The signage was not completely visible. It was blocked by two oxygen cylinders near the back wall. Approximately eight empty oxygen tanks were stored on the floor, in individual racks on the left side of the room designated for "full" tanks, along with approximately twenty-six full or partially full oxygen tanks on the "full" side. There were approximately forty-eight oxygen tanks in the closet total. Empty and full oxygen cylinders were not segregated from each other. Both empty and partial/full oxygen cylinders were stored mixed in with each other in various racks. 2. Observation on 06/15/26 at 2:00 P.M., showed the medication room on Sundial with four empty oxygen tanks and no signage on the door. During an interview on 06/15/26 at 2:00 P.M.,	A2010		

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A2010	Continued From page 2 Certified Medication Technician (CMT) E said he/she guessed that was where the oxygen was stored. The oxygen tanks should be stored in the right place. He/She had only found out where to store the oxygen today. 3. During an interview on 06/16/26 at 11:05 A.M., the Director of Maintenance said he did not touch the oxygen storage at all. All nurses have a key. He thought Central Supply was responsible for oxygen storage. It was nursing's responsibility to ensure the oxygen cylinders were stored appropriately. A representative from a company delivered the oxygen cylinders to the facility on a regular basis, but he was not sure how often staff checked the oxygen storage room for compliance. Hospice oxygen and any extra tanks went into the oxygen closet. Oxygen was not supposed to be stored in the medication room. It all went into the oxygen storage closet. The closet space was approximately 4 feet by 20 feet with approximately 48 oxygen tanks, and this was the only oxygen room in the facility. 4. During an interview on 06/15/26 at 2:34 P.M., the Central Supply/Medical Records Manager said she was responsible for the oxygen storage room. Full and empty tanks should not be stored together. The room was divided into full and empty. There was not a designated space for Hospice oxygen to go. They bring in their own oxygen. She didn't know when Hospice brought in oxygen or where they stored it. She had no control over what Hospice did. Oxygen could be stored in other areas, but she had only made one area for the facility oxygen. She was aware staff and Hospice used the medication room for oxygen storage, but there should have been a sign posted. She had magnetic oxygen signs for staff to use. She expected full/empty signage to	A2010		

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A2010	Continued From page 3 be visible and in place, and for full/empty tanks to be stored separately. NFPA 99 (1999) 4-5.5.2.2 If stored within the same enclosure, empty cylinders shall be segregated from full cylinders. Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed hurriedly. *The higher classification merited due to the extent of the violation.	A2010		
A4074	19 CSR 30-85.042(65) Protective Oversight, Voluntary Leave Each resident shall receive twenty-four- (24-) hour protective oversight and supervision. For residents departing the premises on voluntary leave, the facility shall have, at a minimum, a procedure to inquire of the resident or resident's guardian of the resident's departure, of the resident's estimated length of absence from the facility, and of the resident's whereabouts while on voluntary leave. I/II This regulation is not met as evidenced by: Class II Based on interview and record review, the facility failed to follow one resident's plan of care, which showed the resident was at risk for falls and required two people assistance for turning, positioning, and incontinence care. The resident fell from the bed while one staff member provided care. The resident obtained a contusion (bruise) on his/her forehead and a fractured right femur (broken right thigh bone) (Resident #1). The	A4074		

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A4074	Continued From page 4 census was 115. Review of Resident #1's quarterly Minimum Data Set (MDS), an assessment instrument completed by the facility staff, dated 11/7/25, showed: -Brief Interview for Mental Status was 00, which indicated severe cognitive impairment; -Functional limitation in Range of Motion (ROM) in both upper and lower extremities; -Rejected care one to three days; -Dependent (helper does all the effort. Resident does none of the effort to complete the activity, or the assistance of two or more helpers is required for the resident to complete the activity) for personal and toilet hygiene, shower/bathing, dressing, rolling left to right and transfers; -Always incontinent of bowel; -Diagnoses include neurogenic bladder (bladder does not empty properly due to neurological condition), hyponatremia (low sodium), high cholesterol, anxiety and depression. Review of the care plan (undated), showed: -Focus: Resident was at risk for falls related to gait/balance problems. Psychoactive drug use; -Goal: Will not sustain serious injury through the review date; -Interventions: Have two staff assist resident when turning and repositioning, during treatments, and during incontinence care; Have two staff one on each side of the bed-assisting with turning in bed as the resident was unable to control his/her lower extremities and they may slide out of bed. Dated 06/29/24; -Focus: Resident had a self-care performance deficit related to impaired balance, limited mobility, and multiple sclerosis (MS, disease of the central nervous system); -Goal: Will maintain current level of function in Activities of Daily Living (ADLs, grooming,	A4074		

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A4074	Continued From page 5	A4074		

dressing and bathing) through next review;
-Interventions: Resident required maximum to total assistance with bathing, grooming, dressing and hygiene. He/She needed assistance with eating. The resident needed total assistance of two and a mechanical lift with transfers, date revised 09/09/24.

Review of the progress notes dated 01/21/26 through 01/24/26, showed:
-On 01/21/26 at 5:01 P.M., while resident was being changed, resident was turned to the left side and resident's leg flopped over the bed rail and resident's body went with legs and landed on left side of face and left side of body. The resident had a 2.0 centimeter (cm) by 2.0 cm contusion on the left side of the forehead. Hospice nurse contacted to order a bolstered mattress (a bed designed with built-in, raised foam or air-filled edges along the perimeter). Family and doctor were notified. Neurological (neuro) functions within normal limits. As needed morphine given for head pain;
-On 01/23/26 at 3:22 A.M., family video phoned resident while the nurse was in with the resident for bedtime medication and assisting resident with care. Family discussed with the nurse about pain in right (leg) that was causing the resident to call out. Family requested a stat (immediate) x-ray to be done to rule out any complications with the right leg. Stat order for x-ray put in the computer. About 20 minutes, later the x-ray company phoned to say that they would be out first thing in the morning;
-On 01/23/26 at 3:27 P.M., staff reminded to have two people at all times when positioning resident in bed;
-On 01/23/26 at 4:28 P.M., x-ray to right lower extremity (leg) completed, and results received with acute oblique fracture (fracture that is

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A4074	Continued From page 6	A4074		

diagonal to a bone's long axis) of distal femur (the lower end of the thigh bone that flares outward just above the knee joint). The resident was sent to the hospital.

During an interview on 06/16/26 at 11:30 A.M., Licensed Practical Nurse (LPN) D said the resident required two people assistance for turning and positioning. On 01/21/26, the nurse was not on the unit at the time of fall. When he/she returned to the unit, the Resident Care Specialist (RCS) told the nurse the resident fell. The RCS reported that when he/she was cleaning the resident, the resident's leg flew out of bed. The resident was paraplegic (partial or complete paralysis of the lower half of the body) and the weight of the leg took the resident's whole body, and the resident fell on the floor. The nurse said no one was holding the resident on the other side, so he/she assumed the RCS was providing care alone. When the Resident Care Director (RCD) asked the RCS, the RCS told the RDC he/she was providing care alone. LPN D said he/she was pretty sure the RCS knew the resident required two people assistance for care.

During an interview on 06/16/26 at 3:56 P.M., the RCD said staff know the care needs of the residents by looking on the computer, the hot sheet, or they can ask the nurse. After a fall, the RCD or the Director of Nursing (DON) do an investigation. The investigation consisted of talking with the resident and collecting statements from staff who were involved in the incident. Resident #1 had a history of falls and required total assistance for ADLs and two people assistance for bed mobility and transfers. In January 2026, the resident was being turned in bed when he/she fell. The RCD did not recall if there was a second person assisting the resident.

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A4074	Continued From page 7 During an interview on 06/16/26 at approximately 10:00 A.M., the DON said the facility did not do an investigation because they knew how the resident fell. Review of the handwritten witness statement provided by the facility, dated 01/22/26, showed, the statement was written by RCS G. Statement: (Document any interactions/observations of resident, date/time of observations, place of observation, resident/staff statements) RCS was in the process of cleaning up the resident. RCS G was holding the resident's top part of body over with his/her right hand and was cleaning the resident with his/her left hand, when the resident's leg fell off the bed. Then, the resident's whole bottom part rolled off the bed and RCS G couldn't catch the resident. During an interview on 06/16/26 at 2:25 P.M., RCS G said he/she was familiar with the resident and knew his/her care needs. The resident was alert and oriented times three (person, place and time) and was able to verbalize his/her needs. The resident was paraplegic. RCS G was cleaning up the resident by him/herself, which was the way he/she always provided care for the resident. The resident was turned towards the window. RCS G had one hand holding on to the resident's top part and he/she was cleaning the resident with the other hand, when the resident's leg fell off the bed and the whole body went over. He/She was told the resident needed two-person assistance for transfers. After the incident, he/she was told to use two staff while providing care. During an interview on 06/16/26 at 5:43 P.M., the DON said she would expect staff on the unit to be aware of the resident care needs and if a resident	A4074		

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A4074	Continued From page 8 required two people for care, she would expect two staff to provide care. MO00260460	A4074		
A4075	19 CSR 30-85.042(66) Nursing Care per Res Condition Each resident shall receive personal attention and nursing care in accordance with his/her condition and consistent with current acceptable nursing practice. I/II This regulation is not met as evidenced by: Class II Based on interview and record review, the facility failed to provide treatment consistent with professional standards when the facility failed to ensure ongoing assessment, monitoring, and documentation for one resident (Resident #2) following a fall with injury. After indicators of pain, crying out during care, and multiple administrations of pain medications, the facility failed to document ongoing sources of pain, extent, or progression of the resident's injury and pain complaints for several days. Diagnostic imaging obtained on 1/29/26 revealed an acute fracture of the right pubis bone. The sample was 15. The census 115. Review of the facility's Fall Risk policy, revised September 2025, showed: -Assessment and Recognition: As part of the initial assessment, the physician will help identify residents with a history of falls and risk factors for subsequent falling; -Staff will ask the resident and the caregiver or family about a history of falling;	A4075		

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A4075	Continued From page 9 -The staff and physician should document in the medical record a history of one or more recent falls; -While many falls are isolated resident incidents, a significant proportion occur among a few residents. Those residents may have a treatable medical disorder or functional disturbance as the underlying cause; -In addition, the nurse shall assess and document /report the following: -Vital Signs; -Change in condition or level of consciousness; -Musculoskeletal function, observing for changes in normal range of motion, weight bearing, etc; -Neurological (neuro) assessment. If a resident's fall is unwitnessed or the resident has a head/face injury, monitor vital signs and neurological status for 72 hours (baseline, every 15 minutes times four for the first hour, then every 30 minutes times two for the next hour, then hourly times two for two hours, and then every 12 hours times six for the next 72 hours). Document the vital signs and Neurological assessments on the Neurological Assessment Flow Sheet; -Pain; -Frequency and number of falls since last physician visit; -Precipitating factors, details on how the fall occurred; -All current medications, especially those associated with dizziness or lethargy; -All active diagnosis; -Documentation: Record all findings, interventions, and changes in the resident's condition in the medical record; -Physician Notification: Immediately notify the physician of any significant changes or abnormal	A4075		

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A4075	Continued From page 10	A4075		

findings;
-The staff will document risk factors for falling in the resident's medical record;
-The physician will identify medical conditions affecting fall risk (for example, a recent stroke or medications associated with increased falling risk) and the risk for significant complications of falls (for example, increased fracture risk in someone with osteoporosis or increased risk of bleeding in someone taking an anticoagulant;
-The staff will evaluate and document falls that occur while the resident is in facility including when and where they happened, any observations of the events;
-Falls should also be identified as witnessed or unwitnessed events;
-Cause Identification: For an individual who has fallen, staff will attempt to define possible cause within 24 hours of the fall;
-If the cause of a fall is unclear, if the fall may have a significant medical cause such as a stroke or an adverse drug reaction (ADR) or if the resident continues to fall despite attempted interventions, a physician will review the situation and help identify contributing causes;
-The staff and physician will continue to collect and evaluate information until either the cause of the falling is identified or it is determined that the cause cannot be found or that finding a could would not change the outcome or the management of falling and fall risk;
-Treatment and Management: Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risk of serious consequences of falling;
-Monitoring and Follow up: The staff, with the physician's guidance, will follow-up on any fall with associated injury until the resident is stable and delayed complications such as a fracture or

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A4075	Continued From page 11	A4075		

subdural hematoma (blood builds up between the surface of the brain and the outer lining) have been ruled out or resolved;

-The staff and the physician will monitor and document the resident's response to interventions intended to reduce falling or the consequences of falling. Frail elderly individuals are often at greater risk for severe serious adverse consequences of falls;

-If interventions have been successful in preventing falling, the staff will continue with the current approaches or reconsider whether the measures are still needed if the problem that required the intervention;

-If the individual continues to fall, the staff or the physician will re-evaluate the situation and consider other possible reasons for the resident's falling (besides those that have already been identified) and will re-evaluate the continued relevance of current interventions;

-As needed, the physician will document the presence of uncorrectable risk factors, including reasons why any additional search for causes is unlikely to be helpful.

Review of Resident #2's admission Minimum Data Set (MDS), an assessment instrument completed by the facility staff, dated 12/4/25, showed:
-Severe cognitive impairment;
-Diagnoses included anemia, atrial fibrillation (irregular heart rhythm), heart failure, high blood pressure, gastroesophageal reflux disease (GERD, acid reflux), renal failure, pneumonia, hyperkalemia (high potassium), hyperlipidemia (high number of fats in blood), arthritis, osteoporosis, and Alzheimer's disease;
-No falls in the past month.

Review of the resident's admission fall

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	24122	A. BUILDING: _____ B. WING _____	C 06/16/2026

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A4075	Continued From page 12	A4075		

assessment, dated 1/21/26, showed:
-Score greater than 7, shows high risk;
-The resident was a high risk for falls with a score of 9.

Review of the resident's physician's orders sheet, dated January 2026, showed:
-An order, dated 11/24/25, skin assessment weekly, every day shift, every Monday;
-An order, dated 11/21/25, Morphine (opioid, used to treat severe pain) Sulfate (Concentrate) oral solution 100 milligrams (mg)/5 milliliter (ml). Give 0.25 ml by mouth every four hours as needed (PRN) for pain/shortness of breath (SOB).

Review of the resident's progress notes, dated 1/17/26 at 1:19 P.M., showed Resident Care Specialist (RCS) called over and spoke to this nurse; states resident is on the floor. Resident in dining room lying in fetal position on his/her right side. Resident denies pain. There is a paper on the floor next to the resident. It is likely that resident attempted to pick up the paper on the floor and fell out of the chair. This nurse assessed the resident. Resident denies pain. No injuries noted. Resident able to move all extremities within normal range. Physician and resident's Power of Attorney (POA) notified.

Review of the resident's care plan, revised 1/22/26, showed:
-Focus: I have an activities of daily living (ADL) self-care performance deficit related to Alzheimer's;
-Interventions: I require maximum to total assistance with bathing, hygiene, grooming, dressing, and toileting. I transfer with moderate assistance of one and use a wheelchair for mobility;
-Focus: I had a fall on 1/17 with no injury related

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24122	A. BUILDING: _____ B. WING _____	C 06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARC PROVENCE	605 COEUR DE VILLE DRIVE SAINT LOUIS, MO 63141

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4075	Continued From page 13 to impaired mobility, unaware of safety needs; -Interventions: Continue interventions on fall risk plan; -Focus: I had a fall on 1/21 with a resulting abrasion to my right forehead related to impaired mobility, unaware of safety needs; -Interventions: Continue interventions on fall risk plan; -Treat my abrasion per physician's orders; -The resident's care plan revealed no individualized goals or interventions related to fall prevention or management. Review of the resident's progress notes, showed: -On 1/21/26 at 7:31 P.M., resident found face down on the floor in front of wheelchair. When assessed, it was noted that resident had abrasion on right forehead that measured 4.5 centimeters (cm) by 5 cm. Area cleansed with wound cleaner and Bactroban (topical antibiotic) applied and left open to air. No complaints of pain or discomfort. No other injuries noted. Neuro function within normal limits. Family aware, physician notified. Vitals: Blood pressure 118/68 (normal range 120/80), pulse 78 (normal range 60-100), respirations 19 (normal range 12-20), temperature 97.6 Fahrenheit (F) (normal range 97 to 99 degrees F), and Saturation of Peripheral Oxygen (SpO2) 96% (normal range 96 to 99%); -On 1/22/26 at 3:04 P.M., remains on incident follow up for having an unwitnessed fall and having an abrasion on right side of forehead and small bruise to right corner of eye. Resident has not shown any signs of pain or discomfort. Range of motion within normal limits per resident's baseline. Neuro function within normal limits; -On 1/23/26 at 1:46 P.M., late entry incident follow up; staff to continue to redirect resident when he/she is trying to stand or bend over while	A4075		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24122	A. BUILDING: _____ B. WING _____	C 06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARC PROVENCE	605 COEUR DE VILLE DRIVE SAINT LOUIS, MO 63141

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4075	Continued From page 14	A4075		

in the wheelchair. Staff to continue to keep resident in the line of sight while awake;
-On 1/23/26 at 4:44 P.M., remains on follow up after unwitnessed fall with abrasion to right side of the face. No signs of discomfort reported. Resident able to move extremities with no difficulty. Neuros and vital signs intact and documented.

Review of the resident's neurological checks, dated 1/21/26, showed:
-On 1/21/26, every 15 minutes times four, showed:
-At 8:15 A.M., blood pressure was 140/80;
-At 8:30 A.M., blood pressure was 147/78;
-On 1/21/26, every thirty minutes times two, at 9:00 A.M. and 9:30 A.M., showed refused;
-On 1/21/26, every hour times two at 10:30 A.M. and 11:30 A.M., showed refused;
-On 1/23/26, every shift for 72 hours at 7:00 P.M. and 7:00 A.M., showed refused.
-Staff documented the resident's right and left leg power a 3, mild weakness.

Review of the resident's medical record, dated 1/23/26, showed:
-Review of the resident's Medication Administration Record (MAR), dated January 2026, showed an order, dated 11/21/26, Morphine Sulfate (Concentrate) oral solution 100 mg/5 ml. Give 0.25 ml by mouth every four as needed for pain/SOB was administered on 1/23/26 at 6:27 A.M. Pain was 7 out of 10;
-Review of the resident's progress notes, dated 1/23/26 at 6:27 A.M., Morphine Sulfate oral solution 100 mg/5 ml. Give 0.25 ml by mouth every four hours as needed for pain/SOB. Yelling out during left leg treatment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24122	A. BUILDING: _____ B. WING _____	C 06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARC PROVENCE	605 COEUR DE VILLE DRIVE SAINT LOUIS, MO 63141

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A4075	Continued From page 15 Review of the resident's medical record, dated 1/24/26, showed: -Review of the resident's MAR, dated January 2026, showed an order, dated 11/21/26, Morphine Sulfate (Concentrate) oral solution 100 mg/5 ml. Give 0.25 ml by mouth every four as needed for pain/SOB was administered on 1/24/26 at 11:58 P.M. Pain was 8 out of 10; -Review of the resident's progress notes, showed 1/24/26 at 11:58 P.M., Morphine sulfate oral solution 100 mg/5 ml. Give 0.25 ml by mouth every four hours as needed for pain/SOB. Crying out, facial grimacing, striking out at staff, difficult to console; -At 6:29 P.M., resident remains on fall follow up due to recent fall. Resident refused vital signs after multiple attempts. No complaints of pain this shift. Resident ate 50% today. Will continue to monitor. Review of the resident's skin assessment, dated 1/25/26, showed: -No areas of concern; -Staff documented, "lower extremity edema with weeping. Area cleaned and wrapped daily and as needed"; -No documentation of bruising, abrasions, or other skin conditions. Review of the progress notes, dated 1/25/26 and 1/26/26, showed no follow up information, administration of Morphine, or assessment of injuries. Review of the resident's medical record, dated 1/27/26, showed:	A4075		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24122	A. BUILDING: _____ B. WING _____	C 06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARC PROVENCE	605 COEUR DE VILLE DRIVE SAINT LOUIS, MO 63141

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4075	Continued From page 16 -Review of the resident's MAR, dated January 2026, showed an order, dated 11/21/26, Morphine Sulfate (Concentrate) oral solution 100 mg/5 ml. Give 0.25 ml by mouth every four as needed for pain/SOB was administered on 1/27/26 at 5:00 A.M. Pain was 8 out of 10; -Review of the resident's progress notes, dated 1/27/26 at 5:00 A.M., Morphine sulfate oral solution 100 mg/5 ml. Give 0.25 ml by mouth every four hours as needed for pain/SOB. Resident crying out and complaints of left leg pain. Review of the resident's medical record, dated 1/28/26, showed: -Review of the resident's progress notes, dated 1/28/26 at 4:59 A.M., my colleague and I assisted a resident in waking up (the resident). He/She was in a deep sleep and displayed sign of discomfort by making faces and pushing us away whenever we tried to touch him/her. After dressing the resident, we left him/her in bed; -At 7:27 P.M., resident has been sleeping more during the day. Resident refused to eat breakfast and lunch when staff tried to feed resident, would swing and move head. Morphine given at 11:00 A.M. due to complaint of pain. Call placed to hospice nurse to attempt to get Lorazepam (Ativan, treats anxiety) order changed to Seroquel (mood stabilizer) routinely, hospice nurse stated he/she would call hospice doctor and call facility back; -Review of the resident's MAR, dated January 2026, showed an order, dated 11/21/26, Morphine Sulfate (Concentrate) oral solution 100 mg/5 ml. Give 0.25 ml by mouth every four as needed for pain/SOB was administered on 1/28/26 at 11:27 P.M. Pain was 3 out of 10; -Review of the resident's progress notes, dated	A4075		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24122	A. BUILDING: _____ B. WING _____	C 06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARC PROVENCE	605 COEUR DE VILLE DRIVE SAINT LOUIS, MO 63141

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A4075	Continued From page 17 1/28/26 at 11:27 P.M., Morphine sulfate oral solution 100 mg/ml. Give 0.25 ml by mouth every four hours as needed for pain/SOB. Thrashing and moaning; -At 11:28 P.M., bed rest this evening, liquids offered, refused mouth swab. Moaning and thrashing, Morphine 0.25 mg sublingual and Tylenol liquids given. Will continue comfort medications. Review of the resident's medical record, dated 1/29/26, showed: -Review of the resident's MAR, dated January 2026, showed an order, dated 11/21/26, Morphine Sulfate (Concentrate) oral solution 100 mg/5 ml. Give 0.25 ml by mouth every four as needed for pain/SOB was administered on 1/29/26 at 3:41 A.M. Pain was 8 out of 10; -Review of the resident's progress notes, dated 1/29/26 at 3:41 A.M., Morphine sulfate oral solution 100 mg/ml. Give 0.25 ml by mouth every four hours as needed for pain/SOB. Showing signs of discomfort; -At 3:37 A.M., PRN administration was ineffective. Follow up pain scale was 8. Displayed symptoms of discomfort, with restless legs hanging off the side of the bed; -At 5:56 A.M., Follow up pain scale was 6. PRN administration was ineffective. Still showing signs of discomfort, was able to dress and leave in bed; -At 11:00 A.M., resident alert and oriented times one (alert to person). Resident Care Director (RCD) received orders to obtain x-ray to orbits, eye x-ray minimum four views, femur x-ray minimum two views, right knee x-ray, one or two views. Post falls, complaining of pain when moving right leg and facial swelling and pain. This nurse changed dressing to resident's left lower extremity. Resident restless during dressing	A4075		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24122	A. BUILDING: _____ B. WING _____	C 06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARC PROVENCE	605 COEUR DE VILLE DRIVE SAINT LOUIS, MO 63141

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4075	Continued From page 18 change, and very vocal from the pain. Review of the resident's x-ray results, dated 1/29/26, showed: -Right femur x-ray, minimum two views; -AP (anteroposterior, front to back) and lateral view of the right femur are submitted; -Impression: Acute fractures through the pubis bone on the right. Review of the resident's progress notes, showed: -On 1/29/26 at 5:19 P.M., x-ray results received. Acute fractures through the pubis bone on the right. Degenerative changes in the hip joint and the knee joint. No femoral fractures are noted. This nurse notified RCD. RCD states he/she will call family, this nurse left voicemail for physician, waiting for return call; -On 1/29/26 at 5:49 P.M., results were reported to resident's POA. POA was informed that resident has an acute pubic fracture. POA requested that resident remain in bed until Broda chair (specialized recliner) arrives tomorrow to allow resident to rest. POA is agreeable with current plan of care focused on maintaining resident comfort. POA declined transfer to hospital at this time. Plan of care to continue as discussed. During an interview on 6/16/26 at 11:31 A.M., Licensed Practical Nurse (LPN) D said if a resident had a fall, normally the Resident Care Specialist (RCS) would see it and report it to him/her. LPN D would obtain vitals, range of motion, skin, pain level and if first aid was needed. If he/she finds anything on the resident's skin, it is documented. He/She documents any changes like swelling in the description part of the	A4075		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24122	A. BUILDING: _____ B. WING _____	C 06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARC PROVENCE	605 COEUR DE VILLE DRIVE SAINT LOUIS, MO 63141

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4075	Continued From page 19	A4075		

note. Anything seen on the skin would be documented in the progress notes. If the resident said they were not in pain, they transfer the resident to the bed or chair, contact the physician to notify of the assessment and to check if they want to send resident out. The LPN would notify the family member. LPN D wrote the note on 1/21. The resident sat in the area where the fire place was located. He/She went over there and saw the resident was on the floor. LPN D did not think there were injuries or remember if there was a skin tear. He/She completed range of motion (ROM) and nothing was outside normal limits. He/She had to go back and re-read the notes from 1/17 because nothing was reported about that fall. LPN D said it was either that fall on 1/21 or the one before where something was fractured, and they tried to figure out how it happened. If someone has a fall, they investigate it. After the resident had an x-ray, it showed a fracture. The resident had complaints of pain all the time because his/her legs were swollen and nursing wrapped them. LPN D tried to touch and check for redness or swelling and do ROM to determine which area is hurting. LPN D completed ROM at that time and did not recall any interventions other than keeping a close eye on the resident. The resident had an order for morphine since he/she was on hospice. Initially the abrasion on the head looked like a carpet burn. LPN D came back a couple days later and the resident's eye was black. LPN D looked the resident over and did not see anything else. LPN D said the bruises were not documented on a skin assessment. The resident always had bruises, so that was nothing new. He/She was a one to two person assist, depending on how he/she felt that day. If staff documents refused on a neuro check, after making two attempts to get vitals and they still refuse, he/she would call the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24122	A. BUILDING: _____ B. WING _____	C 06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4075	Continued From page 20	A4075		

physician to notify they were unsuccessful in getting it.

During an interview on 6/16/26 at 3:32 P.M., LPN I said the resident was often teary, but never pertaining to pain. He/She was emotional, more like crying spells. He/She had wounds on the legs and did not have complaints of pain with his/her leg treatment. The only time could had been when removing the dressing. With the wounds, he/she would flinch, but not yell out. The resident did not require any pain medications or morphine with leg treatments.

During an interview on 6/16/26 at 3:26 P.M., LPN J said he/she had a hard time remembering the resident, but the resident was one of the ones that would call out in pain. When he/she administered pain medication, LPN J asked the resident where the pain is located and not get an answer. If LPN J already knows the resident cannot answer, he/she lets that part go. If they are in pain, LPN J will administer the medication since it would cover pain up and down the body.

During an interview on 6/16/26 at 3:57 P.M., the RCD said he/she remembered the resident. He/She had a history of falls, falling out of the wheelchair and believed he/she fell out of bed. He/She often had complaints of pain all over the lower body. Sometimes there was complaints of pain during treatments to the leg, but he/she did not remember if the resident needed pain medications for that. After a fall, he/she would expect a pain assessment to be completed every shift at least. If Morphine was administered, he/she would expect staff to assess where the pain is located if the resident is able to say. There are on-going assessments for 72 hours after a fall. If something pops up, they will monitor and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24122	A. BUILDING: _____ B. WING _____	C 06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARC PROVENCE	605 COEUR DE VILLE DRIVE SAINT LOUIS, MO 63141

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4075	Continued From page 21	A4075		

investigate. They would not do a skin assessment every shift, just an initial skin assessment. If they see bruising during care, they are expected to report it. Any bruising in general should be documented in the skin assessment and risk assessment if staff did not know what happened. On 1/21, the resident fell out of his/her wheelchair again. The abrasion occurred when he/she laid his/her head on the table or when he/she fell. It was the same day. After 1/21, the area around the resident's eye started to bruise and get dark. After that fall, neuro checks were started and the resident had complaints of pain after 1/21. If the resident refused a neuro check assessment, he/she would expect staff to document the refusal and try again later. They should notify the physician and hospice company of the refusals. The RCD would expect the resident's hospice company to be notified if there was an increase of pain. The resident's pain prompted the x-ray. The resident cried out in pain and he/she, along with the Director of Nursing (DON) spoke to the family about it. LPN D did not remember if there were any conversations about the resident's pain or an x-ray prior to that.

During an interview on 6/16/26 at 5:46 P.M., the DON said she would expect a head to toe assessment after a fall to be documented. If a resident refused neuro check assessment, it is expected to be documented. If the resident continues to refuse, the physician and responsible party would be contacted. Any and all bruising on the resident's body is to be documented including the location, size, and color at the time of the fall. Any changes to the bruising should be documented. Pain levels are expected to be evaluated during neuro checks and to see if the pain medication is effective after two to four hours later. If the resident was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24122	A. BUILDING: _____ B. WING _____	C 06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARC PROVENCE	605 COEUR DE VILLE DRIVE SAINT LOUIS, MO 63141

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4075	Continued From page 22 administered Morphine for pain, he/she would expect documentation of the location of pain if the resident can state where and to have nursing further assess. If the resident had worsening symptoms, complaints of pain, facial grimacing, or increase behaviors between 1/24 through 1/28, he/she would expect there to be communication with the physician during that period if they determined it was pain and it was not being controlled. He/She would expect staff to evaluate for pelvic pain, hip pain, shortening, rotation, bruising, or inability to bear weight or any changes. The DON said she looked at the resident's legs. The resident complained of pain that day and either she or the RCD asked to have x-rays completed. The DON could not say how it happened, but the family was also there. She did not recall if it was before or after the x-ray when she assessed the resident. It was because of the complaints of pain. She did not recall if there was pain on the previous days before. She could not recall any assessments prior to 1/29 due to complaints of pain. The resident complained of pain during the x-ray, so the DON was not sue if there were conversations about the resident's pain prior to 1/29. If documented in the record, they would look at a change in condition. The DON was asked what the bruising looked like and she confirmed that it was not only a bruise on the corner of the eye. After the fall was reported, the bruising got worse. It started at the eyes and it followed a track where it spread down the face. It looked like it had spread out. It started on one side and spread to the other. The DON would expect there to be documentation of the bruises. MO00260492 MO00260482 MO00260460	A4075		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24122	A. BUILDING: _____ B. WING _____	C 06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A4083	Continued From page 23	A4083		
A4083	19 CSR 30-85.042(74) Pressure Sore Prevention/Treatment Facilities shall keep residents free from avoidable pressure sores, taking measures toward prevention. If sores exist, staff shall give adequate treatment. I/II This regulation is not met as evidenced by: Class II Based on interview and record review, the facility failed to provide treatment consistent with professional standards of practice when staff documented one resident had an open area on left gluteal fold (horizontal skin crease located directly underneath left buttocks), then failed to assess and document the wound weekly until the resident was see by the wound nurse. In addition, the facility failed to consistently document the wound care that was administered as ordered by the physician/Nurse Practitioner (NP). (Resident #1) The sample was 15. The census was 115. Review of the facility's Prevention of Pressure Injuries policy, dated revised April 2020, showed: -Assess the resident on admission (within eight hours) for existing pressure injury risk factors. Repeat the risk assessment weekly and upon changes in condition; -During the skin assessment, inspect: Presence of erythema (redness or discoloration on the skin); temperature of the skin; soft tissue and edema (swelling); -Inspect the skin daily when performing or assisting with personal care or activities of daily living (ADL, grooming, dressing and bathing); -Identify any signs of developing pressure injuries (example, non-blanchable erythema (a localized	A4083		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24122	A. BUILDING: _____ B. WING _____	C 06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARC PROVENCE	605 COEUR DE VILLE DRIVE SAINT LOUIS, MO 63141

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4083	Continued From page 24	A4083		

redden or discolored area that does not turn white when pressed));
-Inspect pressure points (sacrum (triangle bone located above the coccyx (tailbone)), heels, buttocks, coccyx, elbows, ischium (lower portion of the hip bone), trochanter (hip), etc.);
-Evaluate, report and document potential changes in skin.

Review of the facility's Pressure Sore policy, date latest review January 2025, showed:
-Assessment, appropriate treatment and services are provided to prevent the formation of pressure sores. Residents having pressure sores receive the necessary treatment and services to promote healing, prevent infection and prevent new pressure sores from developing;
-The policy failed to show how often staff should assess and document wounds.

Review of Resident #1's quarterly Minimum Data Set (MDS), an assessment instrument completed by the facility staff, dated 11/07/25, showed:
-Brief Interview for Mental Status score was 00, which indicated severe cognitive impairment;
-Rejected care one to three days;
-Dependent (helper does all the effort. Resident does none of the effort to complete the activity, or the assistance of two or more helpers is required for the resident to complete the activity) on staff for personal/toilet hygiene, shower/bathing, dressing, rolling left to right and transfers;
-Diagnoses include neurogenic bladder (bladder does not empty properly due to neurological condition), hyponatremia (low sodium), high cholesterol, anxiety and depression;
-Was at risk for developing pressure ulcers/injuries;
-One unstageable pressure ulcer (slough (dead tissue) is present, the actual base and condition

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24122	A. BUILDING: _____ B. WING _____	C 06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARC PROVENCE	605 COEUR DE VILLE DRIVE SAINT LOUIS, MO 63141

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4083	Continued From page 25	A4083		

of the ulcer cannot be determined). Wound was not present on admission.

Review of the care plan, in the electronic medical record, showed:
-Focus: Resident had an unstageable pressure wound (slough (dead tissue) is present, the actual base and condition of the ulcer cannot be determined) to the left ischium related to immobility, and incontinence;
-Goal: Pressure wound will show signs of healing and remain free from infection by/through review date;
-Interventions:
--Administer treatments as ordered and monitor for effectiveness;
-- Assess/record/monitor wound healing weekly. Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the Medical Doctor (MD);
--Monitor/document/report as needed any changes in skin status: appearance, color, wound healing, signs and symptoms of infection, wound size (length X width X depth), stage.

Review of the progress notes dated 1/29/25 at 3:09 P.M., showed open area to left gluteal fold that measured 1 centimeter (cm) x 1.5 cm. Area cleansed with wound cleanser, Bactroban (mupirocin, topical antibiotic), calcium alginate (provides a moist environment for wound healing) and applied bordered dressing. The note failed to include the status of the wound perimeter, wound bed (appearance, color, and if there were any signs symptoms of infection) and the stage of the wound.

Review of the skin assessments in the electronic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24122	A. BUILDING: _____ B. WING _____	C 06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4083	Continued From page 26	A4083		

medical record showed, no skin assessment completed for the week of 1/25/25 through 1/31/25.

Review of the physician orders, in the electronic medical record, showed:
-A physician order for left gluteal fold, cleanse with wound cleanser apply Bactroban, calcium alginate and bordered dressing one time a day every Monday, Wednesday, Friday for wound care treatment. Start date was 1/31/25 and was discontinued on 2/26/25;
-A physician order for left gluteal cleft wound three times weekly and as needed. Cleanse with Vashe (wound cleanser) and gauze. Apply triad paste (wound dressing) to peri-wound (area around the wound) cover wound bed with calcium alginate and cover with foam dressing. Start date 2/3/25. Discontinued on 2/12/25;
-A physician order for left gluteal cleft wound three times weekly and as needed. Cleanse with Vashe and gauze. Apply triad paste to peri-wound, cover wound bed with calcium alginate and cover with foam dressing every day shift every Monday, Wednesday and Friday for wound care after shower and as needed for wound saturation. Start date was 2/14/25. Discontinued on 2/26/25 ;
-A physician order for Mupirocin ointment 2 % apply to left ischium topically every Monday, Wednesday, Friday for wound care. Cleanse wound, apply mupirocin and flagyl (antibiotic) 500 milligram (mg) tab crushed and placed to wound bed, cover with (calcium) alginate and bordered foam dressing and as needed. Start date 2/28/25.

Review of the Treatment Administration Record (TAR) dated 2/1/25 through 2/28/25, showed:
-A physician order for left gluteal fold cleanse with wound cleanser apply Bactroban, calcium

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24122	A. BUILDING: _____ B. WING _____	C 06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARC PROVENCE	605 COEUR DE VILLE DRIVE SAINT LOUIS, MO 63141

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4083	Continued From page 27	A4083		

alginate and bordered dressing once a day every Monday, Wednesday, Friday for wound care treatment;

-Documentation on 2/14 and 2/24 were blank;

-A physician order for left gluteal cleft wound three times weekly and as needed. Cleanse with Vashe and gauze. Apply triad paste to peri wound cover wound bed with calcium alginate and cover with foam dressing, in the evening every Monday, Wednesday and Friday for wound care and as needed for wound saturation;

-Documentation showed on 2/3, 2/10 and 2/12 a 9 (other, see progress notes) was documented and blank entries on 2/5 and 2/7;

-A physician order for left gluteal cleft wound three times weekly and as needed. Cleanse with Vashe and gauze. Apply triad paste to peri-wound cover wound bed with calcium alginate and cover with foam dressing every day shift every Monday, Wednesday and Friday for wound care after shower and as needed for wound saturation:

-Documentation on 2/14 and 2/24 were blank;

-A physician order for Mupirocin ointment 2 % apply to left ischium topically every Monday, Wednesday, Friday for wound care. Cleanse wound, apply mupirocin and flagyl 500 mg tab crushed and placed to wound bed, cover with alginate and bordered foam dressing and as needed. Start date was 2/28/25;

-Documentation showed on 2/28, a 9 was documented.

Review of the progress notes dated 2/1/25 through 2/28/25, showed:

-On 2/3/25 at 3:03 P.M., wound treatment to left gluteal fold was completed. Hospice nurse here today new orders received for wound care;

-On 2/26/25 seen by wound nurse today, new orders to cleanse wound to coccyx and apply Mupirocin and flagyl, then cover with alginate and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24122	A. BUILDING: _____ B. WING _____	C 06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARC PROVENCE	605 COEUR DE VILLE DRIVE SAINT LOUIS, MO 63141

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4083	Continued From page 28	A4083		

bordered foam dressing three days a week for 30 days;
-There was no documentation showing why the treatment was not documented/provided on 2/5, 2/7, 2/10, 2/12, 2/14, 2/24 and 2/28 or the physician was notified when the treatment was not provided.

Review of the wound team's progress notes, dated 2/18/25 through 2/26/25, showed:
-On 2/18/25, there was no documentation showing the resident had a wound on the left gluteal fold or left ischium;
-On 2/26/25, Physical exam: Pressure injury to left ischium is covered with black necrotic tissue (death of cells or tissue), the tissue was debrided (remove damaged tissue) to 10% pink tissue;
-Date of onset 2/26/25;
-Location: Left ischial-distal;
-Stage: Unstageable;
-Wound length: 4.5 cm
-Wound width: 3.0 cm
-Wound depth: 0.3 cm
-Status: New
-Exudate (drainage) type: Serosanguineous (composed of serum and blood or yellowish drainage with small amounts of blood) thin pale pink;
-Necrotic tissue: Black necrotic tissue;
-Necrotic amount: 100%
-Treatment: Cleanse wound; apply mupirocin 2% ointment and flagyl 500 mg tablet crushed and placed to wound bed; cover with alginate and a portion of an absorbent dressing (ABD, dressing used to keep wounds dry); secure with Tegaderm (adhesive transparent dressing) every Monday, Wednesday and Friday and as needed; Use flagyl times 30 days starting 2/26/25.

Review of the Medication Administration Record

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24122	A. BUILDING: _____ B. WING _____	C 06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARC PROVENCE	605 COEUR DE VILLE DRIVE SAINT LOUIS, MO 63141

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A4083	Continued From page 29 (MAR)/TAR dated 3/1/25 through 3/12/25, showed: -A physician order for Flagyl 500 mg tablet, apply to left buttock topically every day shift every Monday, Wednesday, Saturday for left ischium for 30 days. Crush the tablet and add to wound bed, cover with alginate and bordered dressing; -Documentation showed: 3/3, 3/10, 3/12 were blank; -A physician order for Mupirocin ointment 2 %, apply to left ischium topically every Monday, Wednesday, Friday and as needed for wound care, cleanse wound, apply mupirocin and flagyl 500 mg tab crushed and place in wound bed, cover with alginate and bordered foam dressing; -Documentation showed: 3/3, 3/10, 3/12 were blank. Review of the progress notes dated 3/1/25 through 3/12/25, showed, there was no documentation on 3/3, 3/10 and 3/12 showing the why the treatment was not documented/provided or the physician was notified when the treatment was not provided. Review of wound nurse progress notes dated 3/12/25, showed: -Physical Exam: Pressure injury to left ischium is covered with purple and necrotic tissue and was debrided to 10% pink tissue. Continue treatment; -Stage: Unstageable; -Wound length: 4:8 cm; -Wound width: 2.5 cm; -Wound depth: 0.5 cm; -Necrotic tissue: yellow slough, other: Purple necrotic tissue; -Necrotic amount 100%; -Status: Unchanged; -Treatment: Cleanse wound, apply mupirocin 2% ointment and flagyl 500 mg tablet crushed and	A4083		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24122	A. BUILDING: _____ B. WING _____	C 06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARC PROVENCE	605 COEUR DE VILLE DRIVE SAINT LOUIS, MO 63141

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4083	Continued From page 30 place to wound bed, cover with alginate and a portion of ABD, secure with Tegaderm every Monday, Wednesday, Friday and as needed. Review of the MAR/TAR dated 3/13/25 through 3/19/25, showed: -A physician order for Flagyl 500 mg tablet, apply to left buttock topically every day shift every Monday, Wednesday, Saturday for left ischium for 30 days. Crush the tablet and place it in wound bed, cover with alginate and bordered dressing; -Documentation on 3/17 was blank; -A physician order for Mupirocin ointment 2 %, apply to left ischium topically every Monday, Wednesday, Friday and as needed for wound care, cleanse wound, apply mupirocin and flagyl 500 mg tab crushed and placed to wound bed, cover with alginate and bordered foam dressing; -Documentation on 3/17 was blank. Review of the progress notes dated 3/13/25 through 3/19/25, showed, there was no documentation showing why the treatment was not documented/provided, or the physician was notified when the treatment was not provided on 3/17/25. Review of the wound nurse notes dated 3/19/26, showed: -Physical Exam: Pressure injury to left ischium is covered with yellow necrotic tissue and was debrided to 10% pink tissue. Continue treatment; -Stage: Unstageable; -Wound length: 3.5 cm; -Wound Width: 2.5 cm; -Wound depth: 1.0 cm; -Necrotic tissue: Yellow slough; -Necrotic tissue: 100%; -Status: Unchanged.	A4083		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24122	A. BUILDING: _____ B. WING _____	C 06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARC PROVENCE	605 COEUR DE VILLE DRIVE SAINT LOUIS, MO 63141

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A4083	Continued From page 31 Review of the MAR/TAR dated 3/20/25 through 3/26/25, showed: -A physician order for Flagyl 500 mg tablet, apply to left buttock topically every Monday, Wednesday, Saturday for left ischium for 30 days. Crush the tablet and piece into the wound bed cover with alginate and bordered dressing; -Documentation on 3/24 was blank and on 3/26 a 9 was documented. -A physician order for Mupirocin ointment 2%, apply to left ischium topically every Monday, Wednesday, Friday and as needed for wound care, cleanse wound, apply mupirocin and flagyl 500 mg tab crushed and placed to wound bed, cover with alginate and bordered foam dressing; -Documentation on 3/24 was blank and on 3/26 a 14 was documented (vitals out of range). Review of the progress notes dated 3/20/25 through 3/26/25 showed, on 3/22/25 at 12:12 P.M., dressing changed to left gluteal cleft by the nurse. There was no documentation showing why the treatment was not documented/provided on 3/24 and 3/26 and no documentation showing the physician was made aware the treatment was not provided. Review of the Wound Nurse notes dated 3/26/25, showed: -Physical exam: Pressure ulcer to left ischium is covered with yellow and purple necrotic tissue and was debrided to 10% pink tissue. Continue treatment; -Stage: Unstageable; -Wound length: 3.5 cm; -Wound Width: 2.5 cm; -Wound volume: 1.0 cm; -Necrotic tissue: Yellow slough; -Necrotic amount: 100%;	A4083		

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	24122	A. BUILDING: _____ B. WING _____	C 06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARC PROVENCE	605 COEUR DE VILLE DRIVE SAINT LOUIS, MO 63141

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A4083	Continued From page 32 -Status: Unchanged. Review of the TAR dated 3/27/25 through 3/31/25, showed: -A physician order for Mupirocin ointment 2 %, apply to left ischium topically every Monday, Wednesday, Friday and as needed for wound care, cleanse wound, apply mupirocin and flagyl 500 mg tab crushed and placed to wound bed, cover with alginate and bordered foam dressing; -Documentation on 3/28 and 3/31 were blank. Review of the progress notes dated 3/27/25 through 3/31/25, showed there was no documentation showing why the treatment was not documented/provided or the physician was notified the treatment was not provided on 3/28/25 and 3/31/25. Review of the MAR/TAR dated 4/1/25 through 4/30/25, showed: -A physician order for Flagyl 500 mg apply to buttock topically every day shift for open wound for 30 days. Crush pill and apply to the wound; -Documentation on 4/3, 4/7, 4/18, 4/22 and 4/30 were blank and on 4/12 a 9 was documented; -A physician order for Mupirocin ointment 2 % apply to left ischium topically every Monday, Wednesday, Friday and as needed for wound care, cleanse wound, apply mupirocin and flagyl 500 mg tab crushed and placed to wound bed, cover with alginate and bordered foam dressing. Discontinued on 4/9/25; -Documentation on 4/7 was blank; -A physician order for Mupirocin ointment 2% apply to left ischium topically every day shift and as needed for wound care. Cleanse wound, apply mupirocin and flagyl 500 mg tab crushed and placed to wound bed, cover with alginate and bordered foam dressing;	A4083		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24122	A. BUILDING: _____ B. WING _____	C 06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARC PROVENCE	605 COEUR DE VILLE DRIVE SAINT LOUIS, MO 63141

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4083	Continued From page 33 -Documentation on 4/18, 4/22 and 4/30 were blank and on 4/12, a 9 was documented. Review of the progress notes dated 4/1/25 through 4/30/25 showed, on 4/7/25, the treatment was completed. There was no other documentation showing why the treatment was not documented/provided or the physician was notified the treatment was not provided on 4/3, 4/12, 4/18, 4/22 and 4/30. No wound nurse notes were provided for 4/1/25 through 4/30/25. Review of MAR/TAR dated 5/1/25 through 5/31/25, showed: -A physician order for Mupirocin ointment 2% apply to left ischium topically every day shift and as needed for wound care. Cleanse wound, apply mupirocin and flagyl 500 mg tab crushed and placed to wound bed, cover with alginate and bordered foam dressing; -Documentation on 5/5, 5/6, 5/9, 5/15, 5/16 and 5/23 were blank. Review of the progress notes dated 5/1/25 through 5/31/25 showed there was no documentation showing why the treatment was not documented/provided or the physician was aware the treatment was not provided on 5/5, 5/6, 5/9, 5/15, 5/16 and 5/23. No wound nurse notes were provided for 5/1/25 through 5/31/25. Review of the MAR/TAR dated 6/1/25 through 6/20/25 showed: -A physician order for Mupirocin ointment 2%, apply to left and right ischium topically every day shift for wound care. Start date was 6/12/25 and	A4083		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24122	A. BUILDING: _____ B. WING _____	C 06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARC PROVENCE	605 COEUR DE VILLE DRIVE SAINT LOUIS, MO 63141

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4083	Continued From page 34	A4083		

discontinued on 6/18/25;
-Documentation on 6/17 was bank;
-A physician order for Mupirocin ointment 2%, apply to left ischium every day and as needed for wound care. Cleanse wound, apply mupirocin and flagyl 500 mg crushed and placed to wound bed, cover with alginate and bordered foam dressing. Discontinued on 6/11/25;
-A physician order for Mupirocin ointment 2 % apply to left ischium topically every day shift for wound care. Start date was 6/19/25;
-Documentation on 6/20 and 6/30 were blank;
-A physician order to cleanse wound on left ischium, apply Mupirocin 2% ointment, and flagyl 500 mg tablet crushed to wound bed; pack with a ¼ Dakins solution (antiseptic) soaked gauze sponge; cover with a portion of an ABD; secure with a large, bordered foam one time a day. Start date was 6/12/25 and discontinued on 6/19/25.
-Documentation on 6/17 was blank and on 6/12 a 9 was documented;
-A physician order for cleanse wound on left ischium, apply mupirocin 2% ointment and flagyl 500 mg tablet crushed to wound bed; pack with alginate; cover with a portion of ABD; secure with a large, bordered foam daily tape bottom of bordered dressing to prevent soiling one time a day for wound care. Start date was 6/20;
-Documentation on 6/20 and 6/30 were blank.

Review of the progress notes dated 6/1/25 through 6/30/25 showed on 6/18, the resident was seen by the wound nurse. There was no documentation showing why the treatment was not documented/provided on 6/12, 6/17, 6/20 and 6/30 or the physician was notified.

No wound nurse notes were provided for 6/1/25 through 6/30/25.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24122	A. BUILDING: _____ B. WING _____	C 06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARC PROVENCE	605 COEUR DE VILLE DRIVE SAINT LOUIS, MO 63141

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4083	Continued From page 35 Review of the MAR/TAR dated 7/1/25 through 7/23/25, showed: -A physician order for Mupirocin ointment 2% apply to left ischium topically every day shift for wound care; -Documentation on 7/7, 7/19 and 7/20 were blank; -A physician order for wound care be to left ischium, cleanse wound; apply mupirocin 2% ointment and flagyl 500 mg tablet crushed to wound bed; pack with alginate; cover with a portion of an ABD; secure with a large, bordered foam daily tape bottom of bordered dressing to prevent soiling one time a day for wound care. Discontinued 7/31/25; -Documentation on 7/7, 7/19 and 7/20 were blank; Review of the progress notes dated 7/1/25 through 7/23/25, there was no documentation showing why the treatment was not documented/provided or the physician was made aware the treatment was not provided on 7/7, 7/19 and 7/20. Review of the wound nurse notes dated 7/23/25 showed: -Physical exam: Pressure injury to left ischium is granulating with undermining present; the wound is larger with evidence of pressure, recommend soaking wound prior to the treatment, continue to pack the undermining area; continue treatment; -Treatment: Cleanse wound with ¼ % Dakin's solution, apply mupirocin 2% ointment and flagyl tablet crushed and placed in wound bed, cover with alginate and a portion of ABD; cover with large foam, secure with Tegaderm daily and as needed; -Stage: Unstageable; -Wound length: 6 cm;	A4083		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24122	A. BUILDING: _____ B. WING _____	C 06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARC PROVENCE	605 COEUR DE VILLE DRIVE SAINT LOUIS, MO 63141

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4083	Continued From page 36	A4083		

-Wound width: 3 cm;
-Wound depth: 2.5 cm;
-Granulation: Pink, dull 50%;
-Necrotic tissue: Yellow slough;
-Necrotic amount: 50%;
-Status: Unchanged.

Review of the MAR/TAR dated 7/24/25 through 7/31/25, showed:
-A physician order for Mupirocin ointment 2 % apply to left ischium topically every day shift for wound care;
-Documentation on 7/28 and 7/30 were blank;
-A physician order for wound care be to left ischium, cleanse wound; apply mupirocin 2% ointment and flagyl 500 mg tablet crushed to wound bed; pack with alginate; cover with a portion of an ABD; secure with a large, bordered foam daily tape bottom of bordered dressing to prevent soiling one time a day for wound care. Discontinued 7/31/25;
-Documentation on 7/28. 7/30 were blank;

Review of the progress notes dated 7/24/25 through 7/31/25, showed, on 7/31/25 at 10:32 A.M., new order received from wound Nurse Practitioner (NP) to change dressing to left ischium every other day, cleanse with Dakin's solution, apply mupirocin ointment, flagyl in wound bed apply Dakin's gauze in wound bed, cover with alginate with border dressing and Tegaderm, change every other day and as needed; There was no documentation showing why the treatment was not documented/provided on 7/28 and 7/30 or the physician was aware when treatment was not provided.

Review of the wound nurse progress notes dated 7/30/25, showed:
-Physical exam: Pressure injury to left ischium is

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	24122	A. BUILDING: _____ B. WING _____	C 06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARC PROVENCE	605 COEUR DE VILLE DRIVE SAINT LOUIS, MO 63141

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4083	Continued From page 37	A4083		

granulating with undermining present, the wound is stable this week with no further evidence of pressure, recommend soaking wound prior to the treatment, continue with frequent turning and repositioning, continue to pack the undermining area. Continue treatment;
-Stage: Unstageable;
-Wound length: 6.0 cm;
Wound width: 3.0 cm;
Wound depth: 2.5 cm;
Granulation: Pink, dull 50%;
-Necrotic tissue: Yellow slough;
-Status: Unchanged.

Review of the MAR/TAR dated 8/7/25 through 8/13/25 showed:
-A physician order for Mupirocin External Ointment 2 % apply to Left ischium topically every day shift for wound care;
-Documentation on 8/8 and 8/11 were blank;
-A physician order for left ischium, cleanse wound with Dakins solution, apply mupirocin 2% ointment and flagyl 500 mg crushed place in wound bed, pack with ¼ Dakins solution gauze that is wet but not dripping, cover with alginate and bordered foam dressing every other day and as needed;
-Documentation on 8/11/was blank.

Review of the progress notes dated 8/7/25 through 8/13/25, showed there was no documentation showing why the treatment was not documented/provided on 8/8/25 and 8/11/25.

Review of the wound nurse notes dated 8/13/25 showed:
-Physical exam: Pressure injury to left ischium is starting to granulate and is stable in size. Continue treatment;
-Stage: Unstageable;

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A4083	Continued From page 38 -Wound length: 5.0 cm; -Wound width: 3.0 cm; -Wound depth: 2.5 cm; -Granulation: Pink dull 40%; -Necrotic tissue: Yellow, slough; -Status: Unchanged. Review of the MAR/TAR dated 8/14/25 through 8/20/25, showed: -A physician order for Mupirocin External Ointment 2%, apply to left ischium topically every day shift for wound care; -Documentation on 8/20 was blank; Review of the progress notes dated 8/14/25 through 8/20/25 showed there was no other documentation showing why the treatment was not provided on 8/20/25. Review of the wound nurses notes dated 8/20/25 showed: -Physical exam: Pressure injury to left ischium is starting to granulate however there is yellow necrotic tissue as well as purple tissue in the wound bed; there continues to be evidence of pressure in the wound bed; wound healing is also compromised by frequent fecal contamination; recommend the use of Tegaderm to help keep the stool out of the wound bed; -Stage: Unstageable. Wound length: 6.0 cm; -Wound width: 4.5 cm; -Wound depth: 2.0 cm; Granulation: Pink dull 50%; -Necrotic tissue: Yellow slough, other: purple tissue; -Status: Deteriorating. Review of the MAR/TAR dated 8/21/25 through	A4083		

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A4083	Continued From page 39 8/27/25, showed: -A physician order for Mupirocin ointment 2% apply to left ischium topically every day shift for wound care; -Documentation on 8/24 and 8/25 were blank; -A physician order for wound care to left ischium, cleanse wound with Dakins solutions, apply mupirocin 2% ointment and flagyl 500 mg tab crushed place in wound bed, pack with 1/4 Dakin's solution gauze that is wet but not dripping, cover with alginate and border foam dressing secure with Tegaderm every other day and as needed every other day. Discontinue date was 8/27/25; -Documentation on 8/25 was blank. Review of the progress notes dated 8/21/25 through 8/27/25 showed, there was no documentation showing why the treatment was not documented/administered on 8/24/25 and 8/25/25. Review of the wound nurse notes dated 8/27/25 showed: -Physical exam: Pressure injury to left ischium is granulating and smaller. Continue treatment. -Wound length; 5.0 cm; -Wound width: 3.5 cm; -Wound depth: 2.0 cm; -Granulation: Pink dull, 70 %; -Necrotic tissue: Yellow slough; -Status: Improving. During an interview on 6/16/26 at 3:40 P.M., the Wound Nurse said when a resident was started on wound care services, she completed a head-to-toe assessment. After the resident was on the case load, the facility's nurse notifies her during her weekly visit if the resident had a new wound. The nurse can also call her between visits	A4083		

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A4083	Continued From page 40 if they had a concern about a wound. The resident was on hospice, and he/she was non-complaint with turning and repositioning. Also, the resident refused to allow staff to provide wound care at times. During an interview on 6/16/26 at 3:50 P.M., the Resident Care Director (RCD) said the nurse on the floor completed the weekly skin assessment. If the nurse found a wound, the nurse should measure and stage the wound. The nurse should also notify the physician to obtain treatment orders and document it. The nurse on the floor was responsible for completing wound care. If a Certified Medication Technician (CMT) was charging the floor, the CMT was responsible for notifying the nurse a treatment needed to be completed. During an interview on 6/16/26 at 5:43 P.M. the Director of Nursing (DON) said if staff discover a wound, staff should assess the wound and document it. The documentation should include the location of the wound, size, stage and a description of what the wound looked like. The DON would expect staff to identify a wound before it was unstageable. The resident only had one wound on his/her buttocks; the Wound Nurse may have identified the area as ischium. The DON would expect staff to follow the facility's policies and procedures. MO00260460	A4083		
A4088	19 CSR 30-85.042(79) Notify Responsible Party-Change in Condition In the event of accident, injury, or significant change in the resident's conditions, facility staff	A4088		

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A4088	Continued From page 41 shall immediately notify the person designated in the resident's record as the designee or responsible party. III This regulation is not met as evidenced by: Based on interview and record review, the facility failed to ensure emergency contact information was updated for one resident (Resident #2) after receiving notification the resident's first emergency contact passed away. In addition, the nursing staff contacted the deceased emergency contact after Resident #2's fall. This resulted in delayed information to the family regarding the resident's fall and injuries. The census was 115. Review of the facility's Notification of Changes policy, reviewed August 2025, showed: -Policy: This facility will immediately inform the resident and consult with the resident's physician, if appropriate, when changes occur. If known, the facility shall also notify the resident's legal representative. The facility shall record and periodically update the address and phone number of the resident's legal representative; -Notification of changes shall include: An accident involving the resident which results in injury and has the potential for requiring physician intervention; -A significant change in the resident's physical, mental, or psychosocial status, such as a deterioration in health, mental, or psychosocial status, in life threatening conditions or clinical complications; -A need to alter treatment significantly; -A decision to transfer or discharge the resident from the facility; -A change in room or roommate assignment; -A change in resident rights under federal or state	A4088		

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A4088	Continued From page 42	A4088		

law regulations pertaining to care of the resident;
-If the resident is deemed unable to comprehend the notification of changes, the responsible party will be informed on the resident's behalf.

Review of Resident #2's contact information, added to the medical record on 11/20/25, showed:
-Family member A was the first contact. The contact type showed financial responsibility, healthcare Power of Attorney (POA), and personal health information;
-Family member B was the second contact. The contact type showed personal health information;
-Family member C was the third contact. The contact type showed personal health information;
-Family member D was the fourth contact. The contact type showed personal health information.

Review of the resident's face sheet, showed he/she was admitted on 11/21/25.

Review of the resident's admission Minimum Data Set (MDS), an assessment instrument completed by facility staff, dated 12/04/25, showed:
-Severe cognitive impairment;
-Diagnoses included: Anemia, atrial fibrillation (irregular heart rhythm), heart failure, high blood pressure, gastroesophageal reflux disease (GERD, acid reflux), renal failure, pneumonia, hyperkalemia (high potassium), hyperlipidemia (high number of fats in blood), arthritis, osteoporosis, and Alzheimer's disease.

Review of the resident's Physician's Orders Sheet (POS), dated January 2026, showed an order, dated 11/24/25, Lorazepam Oral Concentrate (Ativan, used to treat anxiety) 2 milligram (mg)/

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A4088	Continued From page 43	A4088		

milliliter (ml). Give 0.5 ml by mouth every six hours as needed for anxiety.

Review of the resident's progress notes, dated 01/07/26 at 7:39 P.M., showed:
-Lorazepam oral concentrate 2 mg/ml, give 0.5 ml by mouth every six hours as needed for anxiety;
-Anxiety, was informed of the passing of Family Member A;
-Crying.

Review of the resident's progress notes, dated 01/17/26, showed Resident Care Specialist (RCS) called over to household and spoke to this nurse; states resident is on the floor. This nurse entered household. Resident in dining room lying in fetal position on his/her right side. Resident denies pain. There is paper on the floor next to the resident. It's likely that resident attempted to pick up the paper on the floor and fell out of the chair. This nurse assessed the resident. Resident denies pain. No injuries noted. Resident able to move all extremities within normal rage. Physician and resident's POA notified.

During an interview on 06/16/26 at 3:32 P.M., Licensed Practical Nurse (LPN) I recalled writing the progress note. He/She remembered there was a piece of paper on the floor, and he/she believed the resident reached for that. LPN I called the physician and left a message, but did not request a call back because the resident did not have injuries. He/She did not remember who he/she called from the resident's emergency contact list and did not remember talking to anyone specifically. LPN I said he/she would only call one contact. He/She called the POA or first emergency contact. Whoever was number one was who he/she contacted. LPN I was sure he/she left a message.

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A4088	Continued From page 44 During an interview on 06/16/26 at 3:57 P.M., the Resident Care Director said he/she did not know who staff called on 1/17/26. He/She believed they contacted the resident's deceased family member. The facility spoke to Family Member E, who did not know about the fall on 1/17/26. Their name was not in the chart, and they had to get everything switched. The only person on the list was the resident's two daughters and a cousin, but both daughters were deceased. Anyone can update the residents' emergency contact information as long as they have the information. The resident had no one at the time. It was the reason why Family Member E was told about the fall a few days later when Family Member E told facility staff about Family Member A. During an interview on 06/16/26 at 5:46 P.M., the Administrator and Director of Nursing (DON) said the residents have more than one contact, so they can contact the second person. They were not aware of there being an issue with the resident's emergency contact list. They would expect the face sheet to be updated with who was taking over. The expectation is for the staff to call the secondary emergency contact on the list. They would expect staff to have called the next person on the face sheet. MO00260492	A4088		

PLAN OF CORRECTION

Provider/Supplier Name:	#Parc Provence
Street Address, City, Zip:	605 Coeur DeVille Dr. Creve Coeur, Mo. 63141
Date of Survey:	Survey Exit June 17, 2026

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
A2010		
19 CSR 30-85.022(6) Oxygen Storage	This plan of correction is submitted as required under state law and does not constitute an admission on the part of the community that the findings constitute a deficiency or that the scope and severity regarding any deficiencies cited are correctly applied.	
	The community will continue to ensure that Oxygen is maintained in compliance with NFPA 99 (1999).	
	All residents residing in the community have the potential to be affected by this practice	
	The DCS/designee will educate the nursing staff of the proper storage of Oxygen tanks with an emphasis on ensuring: • Oxygen storage racks are labeled with "full" & "empty." • That all full tanks are separated from empty tanks in the proper storage area. • Appropriate "Oxygen in use" signage is on all areas storing Oxygen tanks. • Nursing is to notify Hospice when Oxygen tanks need to be picked up.	
	Oxygen tanks were separated with full tanks placed to the left of the storage closet and empty tanks placed to the right of the storage closet. Additional signage was added to the racks and walls of the storage closet	
	DCS/designee will monitor and complete an audit of the Oxygen storage closet weekly for 4 weeks then monthly for 2 months to ensure all Oxygen tanks are separated appropriately and proper signage is in use and visible.	
	DCS/designee will audit each medication storage room weekly x 4 weeks then monthly for 2 months to ensure no Oxygen tanks are being stored in that area.	
	The community's continued & ongoing correction of this deficiency will be reviewed by the community's QA Committee quarterly for the next 6 months.	07.10.2026

The Administrator signing and dating the first page of the CMS-2567/State Form is indicating their approval of the plan of correction being submitted on this form.

PLAN OF CORRECTION

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A4074		
19 CSR 30-85.042(65) Protective Oversight	This plan of correction is submitted as required under state law and does not constitute an admission on the part of the community that the findings constitute a deficiency or that the scope and severity regarding any deficiencies cited are correctly applied.	
	The community will continue to ensure residents receive 24-hour protective oversight & supervision.	
	Resident # 1 no longer resides in the community.	
	All residents residing in the community have the potential to be affected by this practice.	
	The DCS/designee will educate nursing staff regarding the importance of following care plan interventions to minimize the risk of resident injury such as falls or skin tears. Ongoing training will occur as needed.	
	DCS/designee will monitor and complete an audit of a sampling of residents weekly for 4 weeks then monthly for 2 months to ensure care plan interventions are followed in relation to a resident fall.	
	The community's continued & ongoing correction of this deficiency will be reviewed by the community's QA committee quarterly for the next 6 months.	07.10.2026

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A4075		
19 CRS 30-85.042(66) Nursing Care per Resident Conditions	This plan of correction is submitted as required under state law and does not constitute an admission on the part of the community that the findings constitute a deficiency or that the scope and severity regarding any deficiencies cited are correctly applied.	
	The community will continue to ensure that each resident receives personal attention and nursing care in accordance with his/her condition and consistent with current acceptable nursing practice.	
	Resident # 2 no longer resides in the community.	
	All residents residing in the community have the potential to be affected by this practice.	
	The DCS/designee will educate nursing staff on the Fall Risk policy and review professional nursing standards to ensure follow-up fall assessments are completed; any changes in resident condition from their baseline are documented & reported to the MD and POA. Ongoing training will occur as needed.	
	DCS/designee will monitor & complete an audit on a sampling of resident's records weekly for 4 weeks then monthly for 2 months to ensure follow-up documentation was notated, including any change in resident's condition was reported to the MD and POA with recommendations/orders from the MD documented and completed.	
	The community's continued and ongoing correction of this deficiency will be reviewed by the community's QA committee quarterly for the next 6 months. .	7.10.2026

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A4083		
19 CSR 30-85.042(74) Pressure Sores Prevention/ Treatment	This plan of correction is submitted as required under state law and does not constitute an admission on the part of the community that the findings constitute a deficiency or that the scope and severity regarding any deficiencies cited are correctly applied.	
	The community will continue to ensure that the community keeps residents free from avoidable pressure sores, taking measures toward prevention. If sores exist the community will give adequate treatment.	
	Resident # 1 no longer resides in the community.	
	All residents residing in the community have the potential to be affected by this practice.	
	The DCS/designee will educate nursing staff on the Prevention of Pressure Injuries policy, including wound care with an emphasis on: • Completing weekly skin assessments for all residents and proper documentation of wounds • Pressure ulcer care and prevention • Obtaining orders for wounds and documentation of those treatments in the TAR	
	DCS/designee will monitor & complete an audit on a sampling of resident's records weekly for 4 weeks then monthly for 2 months to ensure skin assessments are completed per policy, any skin alterations identified are documented, MD and POA are notified, treatment order obtained and treatments are completed as ordered.	
	The community's continued and ongoing correction of this deficiency will be reviewed by the community's QA committee quarterly for the next 6 months.	07.10.2026

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A4088		
19 CSR 30-85.042(79)	This plan of correction is submitted as required under state law and does not constitute an admission on the part of the community that the findings constitute a deficiency or that the scope and severity regarding any deficiencies cited are correctly applied.	
	The community will continue to ensure that in the event of an accident, injury or significant change in the resident's conditions, facility staff immediately notify the person designated in the resident's record as the designee or responsible party.	
	Resident # 2 no longer resides in the community.	
	All residents residing in the community have the potential to be affected by this practice.	
	The DCS/designee will educate nursing staff regarding the Notification of Change policy to ensure the residents' change in condition is reported to the responsible party and MD.	
	DCS/designee will monitor and complete an audit on a sampling of resident's record weekly for 4 weeks then monthly for 2 months ensure any incident, accident or significant change in the resident's condition is properly reported to the residents' responsible party.	
	The community's continued and ongoing correction of this deficiency will be reviewed by the community's QA committee quarterly for the next 6 months.	07.10.2026

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