STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265302	A. Building B. Wing	04/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkside Manor	1201 Hunt Avenue Columbia, MO 65202

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to notify one resident's (Resident #1) physician when the resident said he/she did not want to live anymore. The facility census was 77. 1. Review of the facility's Suicide Threats policy, undated, showed: -Resident suicide threats shall be taken seriously and addressed appropriately; -Staff shall report any resident threats immediately to the charge nurse; -The charge nurse shall immediately assess the situation and shall notify the director of nursing of such threats; -After assessing the resident in more detail, the charge nurse shall notify the resident's attending physician and responsible party, and shall seek further direction from the physician; -Staff shall document details of the situation objectively in the resident's medical record. 2. Review of Resident #1's face sheet showed the resident admitted to the facility on [DATE] with diagnoses of generalized anxiety disorder and suicidal ideations. Review of the resident's Electronic Health Record (EHR) showed the health record did not contain a care plan. Review of the resident's nurse's note, dated 04/05/2025 at 6:45 P.M., showed staff documented resident frequently cries. Review showed staff documented they overheard the resident on the phone a few weeks ago, say he/she did not know if he/she wanted to live anymore. Staff member reported this to this nurse, this nurse went and spoke to resident about what was overheard, told him/her if he/she was having these feelings, it would be a good idea to go to the hospital where they would be able to help him/her better with his/her emotional state. Review of the resident's EHR showed the record did not contain documentation staff notified the residents physician of the resident saying he/she did not know if he/she wanted to live anymore. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/05/25 at 6:20 P.M., Licensed Practical Nurse (LPN) said the resident cries all the time. The LPN said a staff member overheard the resident telling someone on the phone he/she did not want to live. The charge nurse said he/she thought the incident was a couple of weeks ago and he/she did not remember which staff member overheard the resident. The LPN said he/she spoke with the resident. LPN A said he/she did not notify the DON or resident's doctor because he/she thought the resident was okay after he/she spoke with the resident. The LPN said he/she did not document the incident at the time because he/she thought the resident was okay. The LPN said he/she was not aware of the resident talking about suicide today. During an interview on 04/07/25 at 10:20 A.M., the DON said he/she would expect to be notified if a resident said they did not want to live anymore. The DON said he/she would expect the resident's doctor to be notified. The DON said the nurse should document the resident's emotional distress and any actions taken to reduce the distress. The DON said he/she was aware the resident had a psychiatric history but was not aware of the resident's diagnosis of suicidal ideations. During an interview on 04/07/25 at 11:52 A.M., the administrator said he/she would expect the charge nurse to notify the residents doctor if a resident talked about suicide. The administrator said the charge nurse is responsible for ensuring the resident is closely monitored and all actions are documented and shared with other staff caring for the resident. MO00252319

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, facility staff failed to complete the required Minimum Data Set (MDS), a federally mandated resident assessment, within the required time frame for one (Resident #1) of one sampled resident. The facility's census was 77. 1. Review of the RAI manual version 3.0 RAI Omnibus Budget Reconciliation Act (OBRA)-required Assessment Summary showed an admission (Comprehensive) MDS completion date no later than 14th calendar day of the resident's admission. 2. Review of Resident #1's Entry Tracking Record MDS, showed the resident admitted to the facility on [DATE]. Review of the resident's electronic health record did not contain a completed MDS or submitted admission assessment within the required time frame. Review showed the admission assessment included a due date of 04/02/25. During an interview on 04/07/25 at 10:20 A.M., the Director of Nursing (DON) said the MDS coordiantor was responsible for ensuring the admission assessment was completed within 14 days of admission. During an interview on 04/07/25 at 10:45 A.M., the MDS Coordinator said he/she had 14 days to complete the admission assessment. The MDS coordinator said the corporate registered nurse (RN) then had three days to sign the completed MDS. The MDS coordinator said the MDS assessment was not complete until an RN signed it. During an interview on 04/07/25 at 9:18 A.M., the administrator said the MDS Coordinator is responsible to complete the residents' MDS within the required time frames. He/She said the residents' admission MDS should be completed within 14 days after admission. The administrator said he/she was not aware of an additional three day period for an RN to sign the MDS assessment. The administrator said he/she was not aware the resident's MDS assessment was not completed. MO00252319

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, facility staff failed to develop a comprehensive person-centered baseline care plan to meet the resident's medical, nursing, mental and psychosocial needs for one resident (Resident #1). The facility's census was 77. 1. Review a baseline care plan showed staff are directed to complete the baseline care plan within 48 hours of admission. After completion, print and file following community protocols 2. Review of Resident #1's medical record showed staff documented the resident was admitted to the facility on [DATE]. Review showed the record did not contain a baseline care plan. During an interview on 04/05/25 at 7:42 P.M., the Assistant Director of Nursing (ADON) said he/she loaded the baseline care plan template into the Electronic Health Record when the resident was admitted . The ADON said the admitting nurse was responsible for completing the baseline care plan upon admission. The ADON said the DON was responsible for ensuring the baseline care plan was completed as required. During an interview on 04/07/25 at 10:20A.M., the DON said the admitting nurse was responsible for completing a comprehensive assessment, which served as the baseline care plan, by the end of the shift on the day of admission. The DON said he/she or the ADON were responsible for ensuring baseline care plans were completed. The DON said he/she was on vacation the week the resident was admitted and the baseline care plan was missed. The DON said he/she was aware the resident had a psychiatric history but was not aware of a recent diagnosis of suicidal ideations. During an interview on 04/07/25 at 11:52 A.M., the administrator said baseline care plans are to be completed upon admission by the admitting nurse. The administrator said he/she would expect the ADON or DON to follow up on missing care plans. MO00252319

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to take appropriate action when one resident (Resident #1) threatened suicide. The facility census was 77. 1. Review of the facility's Suicide Threats policy, undated, showed: -Resident suicide threats shall be taken seriously and addressed appropriately; -Staff shall report any resident threats immediately to the charge nurse; -The charge nurse shall immediately assess the situation and shall notify the director of nursing of such threats; -A staff member shall remain with the resident until the charge nurse arrives to evaluate the resident; -After assessing the resident in more detail, the charge nurse shall notify the resident's attending physician and responsible party, and shall seek further direction from the physician; -All nursing personnel and other staff involved in caring for the resident shall be informed of the suicide threat and instructed to report changes in the resident's behavior immediately; -As indicated, a psychiatric consultation or transfer for emergency psychiatric evaluation may be initiated; -If the resident remains in the facility, staff will monitor the resident's mood and behavior and update care plans accordingly, until a physician has determined that a risk of suicide does not appear to be present; -Staff shall document details of the situation objectively in the resident's medical record. 2. Review of the resident's face sheet showed Resident #1 was admitted to the facility on [DATE]. Review showed admitting diagnoses included generalized anxiety disorder and suicidal ideations. Review of the resident's electronic health record showed it did not contain a care plan. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's nurse's note, dated 04/05/2025 at 6:45 P.M., showed Licensed Practical Nurse (LPN) A documented resident frequently cries, was overheard one time from a staff member in the hall, she was in her room on the phone, saying something in regard to, he/she did not know if he/she wanted to live anymore. Staff member reported this to this nurse, this nurse went and spoke to resident about what was overheard, told him/her that if he/she was having these feelings, it would be a good idea to go to the hospital where they would be able to help him/her better with his/her emotional state. The nurse documented he/she asked the resident if he/she had a plan to hurt him/herself, resident denied he/she had any kind of plan, and he/she had made an appointment with his/her usual doctor over video conference and would be okay to wait until this date. This nurse checked on resident at least every 15 minutes, sometimes more frequently to see how he/she was feeling. After speaking with him/her several times, resident was quite pleasant and said he/she felt a lot better and thanked me for listening. Will continue to monitor resident closely for emotional status and behavior. Review showed the documentation did not contain the date and time of the incident. Review of the resident's Electronic Health Record (EHR) showed the record did not contain: -The date the resident stated he/she did not want to live anymore; -Documentation of Director of Nursing (DON) notification; -Documentation of physician notification. During an interview on 04/05/25 at 6:20 P.M., the LPN A overheard the resident telling someone on the phone he/she did not want to live. The LPN said he/she thought the incident was a couple of weeks ago and he/she did not remember which staff member overheard the resident. LPN A said he/she spoke with the resident. The LPN said he/she did not notify the DON or resident's doctor because he/she thought the resident was okay after he/she spoke with the resident. The LPN said he/she did not document the incident at the time because he/she thought the resident was okay. During an interview on 04/05/25 at 8:00 P.M., the DON said he/she was never notified of any issues with the resident. During an interview on 04/07/25 at 10:20 A.M., the DON said he/she would expect to be notified if a resident said they did not want to live anymore. The DON said he/she would expect the resident's doctor to be notified. The DON said the nurse should document the resident's emotional distress and any actions taken to reduce the distress. The DON said he/she was aware the resident had a psychiatric history but was not aware of the resident's diagnosis of suicidal ideations. During an interview on 04/07/25 at 11:52 A.M., the administrator said he/she would expect the charge nurse to notify the DON and doctor if a resident talked about suicide. The administrator said the charge nurse is responsible for ensuring the resident is closely monitored and all actions are documented and shared with other staff caring for the resident. The administrator said nursing staff should develop a written plan to address any resident's emotional distress. The administrator said he/she was unaware of any issues with the resident. The administrator said he/she was not aware of the resident's diagnosis of suicidal ideations. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/14/25 at 1:05 P.M., the physicians nurse said there was no record of the facility contacting the physician's office between 03/26/25 and 04/04/25 related to suicidal comments or emotional distress. MO00252319