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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>265302   | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                | (X3) DATE SURVEY COMPLETED<br><br>03/31/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Parkside Manor   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1201 Hunt Avenue<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |   |  |
| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>Based on interview and record review, the facility staff failed to ensure one resident (Resident #1) remained free from sexual abuse when Housekeeper B witnessed Certified Nurse Aide (CNA) A hug and kiss the resident on the mouth. The facility census was 76. The administrator was notified on 03/31/26 of Past Non-Compliance which occurred on 03/30/26. On 03/30/26, the administrator suspended CNA A, investigated the allegation, notified the required parties and agencies, in-serviced staff on the facility's abuse and neglect policy, and terminated CNA A on 03/31/26. 1. Review of the facility's Abuse and Neglect Policy, dated 11/2017, showed the purpose is to ensure each resident will be free from abuse. Abuse is defined as verbal, mental, sexual, or physical abuse, misappropriation of resident property and exploitation, corporal punishment or involuntary seclusion, and to ensure immediate reporting of all abuse allegation to the Nursing Home Administrator. Review showed sexual abuse defined as a non-consensual sexual contact of any type with a resident.2. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally required assessment, dated 12/24/25, showed staff assessed the resident as cognitively intact.Review of the resident's plan of care, updated 11/12/25, showed staff assessed the resident as independent for activities of daily living (ADL's). Review of the facility's investigation, dated 03/30/26, showed the administrator documented Housekeeper B reported witnessing CNA A kissing the resident. The Housekeeper B documented he/she was walking down back hall to start cleaning resident rooms. He/She documented he/she saw CNA A walk to the resident's room. He/She said he/she was on his/her way to clean the resident's room, the door was cracked open, he/she looked in the doorway and saw CNA A and the resident kissing. He/She documented he/she did not knock on the door because he/she saw CNA A enter the resident's room before he/she reached the room.Review of CNA A written statement, dated 03/30/26, showed he/she went to the resident's room to tell the resident, the resident's roommate left the facility for an appointment. He/She documented the resident told him/her the resident was nervous so he/she, gave him/her a hug to comfort him/her. He/She documented he/she returned to another hallway of the facility until, being requested to the administrator's office.Review of the resident's statement, dated 03/30/26 at 11:05 A.M., showed he/she documented he/she has found himself/herself in a situation with a staff member that is inappropriate. He/She documented often when he/she is alone or perceived to be alone, he/she is approached and hugged and kissed. He/She said these are not actions initiated by him/her or encouraged by him/her. The resident documented CNA A was greatly appreciated by our entire friend group, and when these incidents occurred, he/she hesitated to do what he/she should have done to maintain homeostasis. He/She documented he/she did not ask to be woken up by CNA A while his/her roommate was in the bathroom, nor did he/she request he/she come into his/her room later in the morning for a hug.During an interview on 03/31/26, at 10:32 A.M., CNA A said, at approximately 9:00 A.M. on 03/30/26, he/she hugged the resident because the resident was upset regarding his/her roommate having a medical procedure. He/She said he/she did not kiss the resident. He/She said staff trained him/her regarding abuse and neglect of residents, including sexual abuse, but he/she said hugging residents is not considered inappropriate. During an interview on 03/31/26, at 10:37 (continued on next page)</p> |   |  |

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

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>A.M., the administrator said the resident has not made prior allegations regarding any staff or residents being physically inappropriate. During an interview on 03/31/26, at 10:52 A.M., Housekeeper B said between 8:00 A.M. and 9:00 A.M. on 03/30/26, he/she was walking down the hallway with his/her cleaning cart, and observed CNA A walk to the nurses' station from the direction of the resident's room, look around the area, and then quickly went back to the resident's room. He/She said he/she went to the resident's room to clean the room, quietly knocked on the door, and looked into the room. He/She said he/she saw CNA A and the resident in a full hug, and CNA A was kissing the resident on the mouth. He/She said he/she reported the incident to Housekeeper C, who reported the incident to the Administrator. During an interview on 03/31/26, at 11:48 A.M., Housekeeper C said Housekeeper B notified him/her he/she witnessed CNA A hugging and kissing the resident on the mouth. Housekeeper C said he/she immediately reported the incident to the Administrator. During an interview on 04/01/26, at 11:00 A.M., the resident said CNA A would come into his/her room when his/her roommate was not in the room, or the roommate was asleep, and hug and kiss him/her. He/She said on 03/30/26, in the morning, CNA A came into his/her room, hugged him/her, and kissed him/her on the mouth. He/She said he/she did not want to kiss CNA A, and he/she felt uncomfortable. He/She said he/she heard someone come into the room, but he/she did not know who. He/She said he/she did not tell anyone about the incidents because he/she did not want CNA A to treat him/her or his/her friends any differently. Complaint #2963341</p> |   |  |