STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265591	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkdale Manor Health & Rehabilitation	814 West South Avenue Maryville, MO 64468

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 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** 51626 Based on observation, interviews and record reviews, the facility failed to assure staff followed acceptable standards of practice for one (1) of the five (5) sampled residents, (Resident #1), when staff failed to follow provider orders, remove a resident's surgical staples in a timely manner, and charted that the surgical staples had been removed per provider orders and were not actually removed. The facility census was 24. The facility did not provide policies and procedures relating to physician orders and weekly skin assessments. Review of the facility's policy for Wound Care, revised October, 2010, showed: - The purpose of this procedure is to provide guidelines for the care of wounds to promote healing; - Verify that there is a physician's order for this procedure; - Review the resident's care plan to assess for any special needs of the resident; - The following information should be recorded in the resident's medical record: - (1.) The type of wound care given. - (2.) The date and time the wound care was given. - (4.) The name and title of the individual performing the wound care. - (6.) All assessment data obtained when inspecting the wound. - Report other information in accordance with facility policy and professional standards of practice. 1. Review of Resident #1's medical record showed: - The resident was admitted to the facility on [DATE] following surgery to correct broken bones in both legs; (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The resident's surgical incisions on both legs had been closed using surgical staples; - Provider orders for staple removal read: Start Date: 10/22/2024 Remove staples one time only for staple removal for one day; - The resident's treatment record shows staple removal charted as completed on 10/22/2024; - A mobile x-ray of the resident's legs was ordered by the provider on 10/24/2024. The facility failed to include any indication the x-ray was completed or resulted in the resident's medical record; - Weekly skin assessments were charted in the resident's treatment record as complete on 10/27/2024, 11/03/2024, and 11/10/2024; - Neither of the two users who documented performing a complete skin assessment on the resident recognized, reported, or intervened to ensure the resident's healing was not delayed by staples still in the resident's skin; - The resident was scheduled for a follow-up appointment on 11/06/2024 which was missed and had to be rescheduled for 11/11/2024; - The resident's surgical staples were removed on 11/13/2024, five weeks after surgery; - The resident was alert and oriented and capable of making decisions and verbalizing needs with a Brief Interview for Mental Status (BIMS)score of 15, indicating the resident was cognitively intact. During an interview on 12/04/2024 at 10:15 A.M., Resident #1 said: - He/She was incredibly upset about how long it took the facility to remove his/her surgical staples and he/she was so fed up with the situation. During an interview on 12/04/2024 at 2:23 P.M., the facility administrator said: - Resident #1's original follow-up appointment had been scheduled by the hospital prior to the resident's admission to the facility. The follow-up appointment had been titled virtual and did not contain any provider contact information, which led facility staff to believe this was not an in-person appointment and this is the reason the first appointment was missed; - He/She had attempted to call the hospital that had made the appointment for clarification but did not receive a call back for two (2) days and by the time the return call was received, the resident had already missed the appointment; - The x-ray the provider ordered on 10/24/24 was a mobile x-ray and the result summary was sent directly to the resident's orthopedic (bone doctor) provider. The provider required the resulting x-ray to be sent to him on a disc which the mobile x-ray company was unable to accomplish so a second x-ray was ordered out of the facility. The results of this x-ray were sent directly to the orthopedic provider and were never seen by facility nursing staff. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Facility administration was not aware that the resident's surgical staples had not been removed until 11/10/2024. When administration became aware of the staples still being in place, it was discovered the facility did not have any staple removal kits. The kits were ordered but the resident's family presented to the facility with kits they had purchased themselves. The facility nursing staff used these kits to remove the resident's staples on 11/13/24. - Usually, the facility social services director would schedule and confirm follow-up appointments are scheduled for residents, but that at the time he/she was serving as both the facility administrator and the social services director due to staffing complications. - Nursing staff is expected to chart tasks as completed only after they are finished. MO245146