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	03/17/2026

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on interview and record review the facility failed to ensure sufficient number of nursing staff (including aides) to respond to residents call lights timely. This affected three (Resident #1, #2, and #3) of four sampled residents. The facility census was 30.Review of the facility Staffing policy, dated October 2017, included staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care. The facility will provide enough staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment.Review of the facility policy titled Answering the Call Light, dated March 2021, included: - The purpose of the procedure is to ensure timely response to the resident's requests and needs; -If the resident needs assistance, indicate the approximate time it will take for you to respond; If the resident request is something you can fulfill, complete the task within five minutes if possible; -If uncertain as the whether or not a request can be fulfilled or if you cannot fulfill the residents request, ask the nurse supervisor for assistance. Review of the facility's 802 form showed 19 of 30 residents required assistance with care.Review of the facility's staffing schedule, dated 3/6/26, showed: - The facility had one nurse working from 6:00 P.M. to 6:00 A.M.; - The Director of Nursing (DON) worked in the roll of a nurse aide from 6:00 P.M. to 6:00 A.M.Review of the facility's staffing schedule, dated 3/7/26, showed: - The facility had one nurse working from 6:00 P.M. to 6:00 A.M.; - The DON worked in the role of a nurse aide from 6:00 P.M. to 6:00 A.M. Review of the facility's staffing schedule, dated 3/8/26, showed: - One nurse working from 6:00 P.M. to 6:00 A.M.; - The DON worked in the role of a nurse aide from 6:00 P.M. to 2:00 A.M.; - When the DON left at 2:00 A.M. a nurse aide took over for the rest of the shift. Review of the facility's staffing schedule, dated 3/16/26, showed: - One nurse working from 6:00 P.M. to 6:00 A.M.; - One nurse aide working from 6:00 P.M. to 6:00 A.M.1.Review of Resident #1's care plan, dated 12/4/25, showed: -The resident required assistance with physical mobility but was very active mentally, with intact cognition; -The resident was continent of bowel and bladder and required a sit to stand to transfer to the toilet; -The resident had limited physical mobility related to cerebral palsy. Review of the facilities call light log dated 3/1/26 through 3/17/26 showed: -On 3/7/26 at 8:44 P.M. the resident turned on his/her call light staff turned off the call light 47 minutes and 51 seconds later; -On 3/8/26 at 4:14 P.M. the resident turned on his/her call light staff turned off the residents call light 46 minutes and 38 later; -On 3/16/26 at 6:04 P.M. the resident turned on his/her call light staff turned off the residents call light 35 minutes and 21 seconds later; During an Interview on 3/17/26 at 12:50 P.M. Resident #1 said: -There is not enough staff to take care of me; - Recently when he/she pressed the call light he/she waited a long period of time for staff to responded and when they did not, he/she wet the bed. -This made him/her feel frustrated and embarrassed since he/she was continent of urine. -He/she is able to use the bathroom if staff can get him/her to the bathroom in time; 2.Review of Resident #2's care plan, dated 5/30/25, showed: - He/she is cognitively intact; -He/she has limited physical mobility due to weakness and chronic obstructive pulmonary disorder(COPD); -He/she is at risk for falls; -He/she requires assistance from staff with activities of daily living; Review of the facilities call light log dated 3/1/26 through 3/17/26 showed: -On 3/1/26 at 10:52 A.M. the resident (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	turned on his/her call light and staff turned off the call light 42 minutes and six seconds later; -On 3/1/26 at 7:44 P.M. the resident turned on his/her call light staff turned off the call light 42 minutes and five seconds later; -On 3/6/26 at 6:45 P.M. the resident turned on his/her call light and staff turned off the call light 54 minutes and 57 seconds later; -On 3/7/26 at 7:11 P.M. the resident turned on his/her call light and staff turned off the call light 45 minutes and 27 seconds later; -On 3/15/26 at 6:34 P.M. the resident turned on his/her call light and it took staff 99 minutes and 59 seconds to answer the resident's call light. During an Interview on 03/17/2026 at 11:30 A.M. the resident said: -There was not enough staff to take care of him/her and other residents; -Sometimes it would take one and a half to two hours before call lights would be answered; -He/she was frustrated because staff do not come and assist him/her when using the call light to ask for staff assistance with ADLS. -He/She cannot count on staff to answer his/her call light.3.Review of Resident #3's care plan, dated 1/12/26, showed: -The resident had multiple falls with no injury due to unsteady gait; -The resident was incontinent of urine due to impaired mobility. -Cognition was intact.Review of the call light log dated 3/1/26 through 3/17/26 showed: -On 3/1/6 at 5:27 A.M. the resident turned on his/her call light and staff turned off the call light 55 minutes and 54 seconds later; -On 3/7/26 at 9:00 P.M. the resident turned on his/her call light and staff turned off the call light 32 minutes and 10 seconds later.During an interview on 03/17/2026 at 4:00 P.M. the resident said: -The staff are busy all the time and not available when he/she needs help; -He/she had wet his/her pants due to having to wait for the call light to be answered, this made her feel angry and embarrassed. During an Interview on 03/17/2026 at 1:00 P.M. Certified Nursing Assistant (CNA) A said: -Some days there is not enough staff working in the facility. -The past two weeks staffing has been consistently short with not enough staff to cover the halls and demands of the call lights. - Several staff members quit due to having a heavy workload; -All staff try to answer call light as quickly as possible, however breakfast and lunch times were the busiest times for call lights and staff are busy with meal service. During an interview on 03/17/2026 at 1:20 P.M. Registered Nurse (RN) A said: -The previous administrator had tried to get agency staff to come into the building to ease the workload but cooperate did not allow this to occur; -Call lights had been answered slowly due to not having enough staff and this causes delays in resident's care.During an interview on 03/17/2026 Nursing Assistant (NA) A said: -There is not enough staff to answer call lights timely; - He/she felt like he/she was unable to keep up with the needs of the residents due to their not being enough staff. During an interview on 03/17/2026 at 3:00 P.M. an anonymous staff member said: -He/she had attempted to advocate to bring agency staff into the facility to ease the workload since it was difficult to get all shifts covered, but was unsuccessful; - He/she feels that it was a disservice to the resident's to not have enough staff to care for all of the residents.During an Interview on 03/17/2026 at 4:10 P.M. the Director of Nursing (DON) said: -She had to work frequently as a charge nurse or a nurse aide instead of performing DON duties due to low staffing; -The goal was to answer call lights within five to 15 minutes, but the current staffing is not able to meet that expectation currently. During an interview on 03/17/2026 at 4:14 P.M. the Regional Nurse said the goal was for residents call lights to be answered within 15 minutes but depending on how busy the day was it may take staff longer to respond.Intake 2797627