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	06/25/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to protect two residents (Resident #31 and #12) right to be free from physical and verbal abuse, when Resident #11, pushed resident #31 against a wall and when Resident #11 ran at Resident #12 with raised fists and threatened to kill him/her. This affected two of three sampled residents (Resident #31 and #12). The facility census was 33. Review of the facility's policy titled Abuse Prevent Program, dated December 2016, showed:-Residents had the right to be free from verbal and physical abuse;-The facility will protect residents from abuse;-The facility will implement policies and procedures to prevent abuse or mistreatment of residents. I think it would be best to move Resident #11's information to the top since this person was involved in both incidents. 1.Review of Resident #11's Quarterly Minimum Data Set (MDS), a federally mandated assessment completed by facility staff, dated 04/17/26, showed:-Severe cognitive impairment;-Supervision with ADLs-Diagnoses included: dementia and depression. Review of the resident's care plan dated 06/23/26 showed:-Assist of one for ADLs;-Dependent on staff for meeting emotional, intellectual, physical and social needs related to cognitive deficits;-Impaired thought process that sometimes caused the resident to display behaviors of frustration;-Monitor for specific triggers that cause the resident to display behaviors and report findings;-The care plan did not identify specific triggers for the resident's behaviors or interventions to mitigate them.Review of the resident's nurse's notes showed:-On 02/12/26, the resident wandered the hallways, cussing at staff, threatening to kill you all. The resident attempted several times to go into other resident's rooms, walked up to another resident that was in the main area and started to yell at him/her. Staff attempted to redirect the resident several times. Resident became very upset yelling at staff when he/she was in his/her room.-On 02/21/26, the resident wandered into several residents' rooms, yelling and cussing at them. The resident threatened to hit and or kill the other residents; -On 03/2/26, the resident was up and down the hallways. The resident was agitated with another resident, yelling and arguing;-On 04/17/26, the resident had been pacing hallways all day. This continued into next shift. The resident said he/she wanted the resident next door to wipe his ass and entered the other resident's room. The resident continued with foul language, bared teeth and attempted to strike out at staff.-On 06/09/26. the resident was moved to the Memory Care Unit. -On 06/10/26, the resident was highly agitated, slamming his/her door aggressively and staff had been unable to reorient resident.-On 06/19/26 the resident had been having increased behaviors, and cussing at staff, and other residents.-On 06/17/26, the resident was agitated called the staff vulgar names and cursing at them. The resident said he/she needed to go to the store to buy cat food. The resident went to his/her room. The resident then came back out of his/her room. Resident #31 was out of his/her room. Resident #11 followed Resident #31 down to Resident #31's room and shoved Resident #31 into the wall.-On 06/24/26, the resident was agitated off and on through the evening. The resident was cursing and yelling at staff. The resident had pushed and hit staff. The resident threw books off the shelf in the dining room area. During an interview on 06/25/26 at 2:01 P.M., Certified Nurses Aide (CNA) B said:-He/She worked on the night Resident #11 pushed resident (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#31;-Resident #11 often pushed staff;-Resident #11 often yelled at resident #31;-Resident #11 hit CNA B in the face;-Resident #31 stood in the hall when resident #11 walked back to his/her room;-Resident #11 walked toward resident #31; -Resident #11 pushed resident #31 into the wall;-CNA B was the only staff member on the memory care unit when resident #11 pushed resident #31;-Resident #31 told CNA B he/she was afraid of resident #11;-CNA B was not instructed to do 5 minute checks;-No extra staff came to help him/her with care on the memory care unit that night;-Every time resident #31 saw resident #11, resident #11 went back to his/her room;-Resident #11 told resident #12 he/she would kill resident #12;-Resident #12 was moved back to the front hall;-He/She had told the DON and the Administer about how resident #31 felt about being around resident #11.-He/She did not know why resident #31 could not be moved farther away from resident #11;-Resident #11's room was across the hall from resident #31;-The interventions were medication changes;-No updated directives or care interventions were provided to staff following the incident.During an interview on 06/25/26 at 2:12 P.M., Registered Nurse (RN) said:-He/She worked the night Resident #11 pushed #31 into the wall;-No new training was provided after the incident:-No new resident specific triggers were identified to prevent resident #11 from having another behavior;-No new interventions were put into place.2. Review of Resident #31's MDS, dated [DATE], showed:-Severe cognitive impairment;-The resident used a cane;-Supervision with Activities of ADLs;-Diagnoses included: Post Traumatic Stress Disorder (PTSD), a condition that develops after experiencing or witnessing a life-threatening event, dementia and anxiety.Review of the resident's care plan dated 05/20/26, showed:-The resident was dependent on staff for meeting emotional, intellectual, physical and social needs;-The resident had a diagnosis of PTSD;-Staff to monitor for triggers that may be related to trauma on going;-The resident had a diagnosis of anxiety;-Monitor mood patterns for signs and symptoms of depression and anxiety;-The care plan did not address specific triggers related to trauma or interventions.Review of the resident's nurse's notes showed:-06/17/26, the resident went out of his/her room for coffee and was confronted by resident #11;-Resident #11 shoved Resident #31 into the wall causing Resident #11 to drop his/her cane;-The resident showed no physical injuries.Review of the facility's investigation dated 06/17/26 showed:-Two staff on the unit reported resident #11 had been agitated;-Resident #11 had pushed resident #31;-Resident #31 stumbled and fell into the wall and dropped his/her cane;-Resident #11 was verbally threatening resident #31.Observation on 06/23/26 at 7:43 P.M., showed:-One staff member on the memory care unit;-Resident #31 sat at the table in the dining room drinking a cup of coffee;-Resident #11 sat in a recliner in the dining room a few feet from resident #31;-Resident #11 got up from the recliner and walked toward the dining room table that resident #31 sat at;-Resident #31 got up from the dining room table, and walked back to his/her room as soon as resident #11 walked toward the dining room table;-Staff got up to assist resident #11.During an interview on 06/24/26 at 02:49 P.M., the resident's responsible party said:-He/She was notified the resident had been pushed by another resident in the memory care unit;-He/She expected the facility to keep resident #31 safe.During an interview on 06/25/26 at 9:16 A.M., CNA A said: -Resident #11 had frequent episodes of aggression before he/she was moved back to the memory care unit;-Resident #11 pushed resident #31 into a wall one night and started to go after resident #12; -Resident #11 tried to grab CNA A around the throat;-The definition of abuse is to intentionally hurt someone else;-When Resident #31 was pushed by Resident #11 that was abuse.3.Review of Resident #12's Quarterly MDS dated [DATE], showed:-Severe cognitive impairment;-Supervision with ADLs;-Diagnoses included: Alzheimer's Disease, depression and asthma.Review of the resident's care plan dated, 06/17/26 showed:-The resident will have physical and emotional needs met without increased emotional distress;-The resident had a mood problem related to dementia;-Monitor and report increased agitation and/or if the resident feels threatened by others.Review of nurse's notes for the resident dated 06/19/26 showed:-Resident #11 stood at the nurse's desk;-Resident #12 walked toward the smoke area with staff;-Resident #11 saw resident #12 and charged at Resident #12 with raised fists;-Resident #11 had his/her fists raised and yelled at resident #12 he/she was (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	going to kill that son of a bitch;-Staff removed resident #12 from the memory care unit and moved him/her off the memory care unit.-Resident #11 remained on the memory care unit.During an interview on 06/24/26 at 03:12 P.M., the resident's family said:-He/She was notified the resident had moved off the memory care unit;-He/She was informed that the resident had been yelled at by another resident on the memory care unit;-He/She expected the facility to keep the resident safe.During an interview on 06/25/26 at 2:01 P.M., the DON said:-Abuse is on purpose and intended;-Resident #11 initially pushed resident #31 into the wall;-Resident #11 had medication changes as soon has he/she pushed resident #31;-A mental health professional had not assessed the resident;-Resident #12 was moved off the memory care unit after resident #11 charged at him/her;-Resident #31 cannot be moved off the memory care unit;-Resident #31 and resident #11 rooms across the hall from each other;-No room changes had been made on the memory care unit;-No changes have been made to staffing in the memory care unit;-The facility was responsible for keeping all residents safe. During an interview on 06/25/26 at 2:12 P.M., the Administrator said:-Abuse was whatever the Center's for Medicare and Medicaid Services (CMS) said it was;-Abuse was done on purpose and intended;-All residents have the right to feel and be safe.Intake 3046672