PRINTED: 02/27/2026
FORM APPROVED

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05511N	A. BUILDING: _____ B. WING _____	C 02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE MANOR LLC	300 S SAINT CHARLES ST BOWLING GREEN, MO 63334

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A4777	19 CSR 30-86.047(36) Proper Care Per Individual Service Plan Residents shall receive proper care as defined in the individualized service plan. I/II This regulation is not met as evidenced by: Class I* Based on interview and record review, the facility failed to provide one resident (Resident #1), in a review of three residents, who was a known choking risk and who staff assessed as alert and oriented to person only, a pureed (foods blended to a smooth, pudding-like consistency, requiring no chewing) diet as ordered by the physician. On 02/10/25 at 10:20 A.M., Nurse Aide (NA) A passed morning snacks. Resident #1 was in his/her room and requested a banana. NA A assisted the resident in his/her wheelchair to the dining room, peeled a ripe banana, broke off a piece (NA A demonstrated with his/her fingers a one-to-two-inch length) and gave Resident #1 the one-to-two-inch piece of intact banana. At 10:23 A.M. the resident choked, started coughing and coughed up a piece of banana before no longer making noise or able to cough. The Director of Nursing (DON) and NA B performed the Heimlich maneuver (a procedure for dislodging an obstruction from a person's windpipe by sudden strong abdominal thrusts) and called 911. At 10:32 A.M. Emergency Medical Services (EMS) arrived and the resident expired at 10:38 A.M. The facility census was 44. Review of the facility's undated Emergency Medical Procedures policy showed the following: -It was the facility policy to provide procedures that would ensure the welfare, health and safety of residents who required emergency medical assistance;	A4777	The administrator and DON has conducted education with all staff to educate them on the different types of diets, where the list of diets & residents diets are located in kitchen, on face sheets and in the transfere book. 2/11/26 The facilities FNP came to facility and reviewed each residents diet. The DON ensured the diets were accurate on the dietary list in kitchen, on residents face sheets on residents ISP & in residents ISP 2/18/26 The administrator shall implement a policy on following physicians orders including but not limited to physicians ordered diets. 3/4/26

Missouri Department of Health and Senior Services
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Parker Hartsuck — TITLE: Administrator — (X6) DATE: 3/5/26

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A4777	Continued From page 1 -Medical emergency is defined as a severe injury or illness that caused a threat to life or limb and required prompt and appropriate action. During an interview on 02/11/26 at 11:30 A.M., the Administrator said the facility did not have a written policy regarding following physician orders including diet orders or following the Individual Service Plan (ISP - plan of care). She expected staff to follow physician's orders, provide residents their ordered diets, and follow each resident's ISP. Review of Resident #1's ISP updated May 2025 showed the following: -Oriented to person, place, and time; -Appetite was good, independent in eating. -Pureed diet with thin liquids; -Provide three meals and two snacks daily; -Monitor and report any concerns. Review of the resident's monthly summary dated January 2025 showed the following: -Alert and oriented only to person at times; -Regular pureed diet with thin liquids diet; -Resident compliant with treatment plan. Review of the resident's Physician Order Sheet (POS) dated 05/23/25 showed the following: -Diagnoses of anxiety, weakness, gastric reflux, reduced mobility, heartburn, unsteady on feet, and history of blood clot in the lung; -Diet changed from mechanical soft consistency (easy to chew foods with finely diced meat) with thin liquids to a regular pureed consistency diet with thin liquids. Review of the resident's nurses' note dated 02/10/26 at 1:51 P.M., showed the DON documented the resident was in the dining room	A4777	The DON has implemented a program (Dinning RD) that provides the facility with education on each diet. This information will made available to all staff but will be kept in Kitchen. 3/9/24 The DON & Administrator shall monitor each resident's diet needs and encourage them to follow their physician ordered diets. If they choose not to follow diet it shall be documented and Provider will be Notified. 3/1/24	

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A4777	19 CSR 30-86.047(36) Proper Care Per Individual Service Plan Residents shall receive proper care as defined in the individualized service plan. I/II This regulation is not met as evidenced by: Class I* Based on interview and record review, the facility failed to provide one resident (Resident #1), in a review of three residents, who was a known choking risk and who staff assessed as alert and oriented to person only, a pureed (foods blended to a smooth, pudding-like consistency, requiring no chewing) diet as ordered by the physician. On 02/10/25 at 10:20 A.M., Nurse Aide (NA) A passed morning snacks. Resident #1 was in his/her room and requested a banana. NA A assisted the resident in his/her wheelchair to the dining room, peeled a ripe banana, broke off a piece (NA A demonstrated with his/her fingers a one-to-two-inch length) and gave Resident #1 the one-to-two-inch piece of intact banana. At 10:23 A.M. the resident choked, started coughing and coughed up a piece of banana before no longer making noise or able to cough. The Director of Nursing (DON) and NA B performed the Heimlich maneuver (a procedure for dislodging an obstruction from a person's windpipe by sudden strong abdominal thrusts) and called 911. At 10:32 A.M. Emergency Medical Services (EMS) arrived and the resident expired at 10:38 A.M. The facility census was 44. Review of the facility's undated Emergency Medical Procedures policy showed the following: -It was the facility policy to provide procedures that would ensure the welfare, health and safety of residents who required emergency medical assistance;	A4777		

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A4777	Continued From page 1	A4777		

-Medical emergency is defined as a severe injury or illness that caused a threat to life or limb and required prompt and appropriate action.

During an interview on 02/11/26 at 11:30 A.M., the Administrator said the facility did not have a written policy regarding following physician orders including diet orders or following the Individual Service Plan (ISP - plan of care). She expected staff to follow physician's orders, provide residents their ordered diets, and follow each resident's ISP.

Review of Resident #1's ISP updated May 2025 showed the following:
-Oriented to person, place, and time;
-Appetite was good, independent in eating.
-Pureed diet with thin liquids;
-Provide three meals and two snacks daily;
-Monitor and report any concerns.

Review of the resident's monthly summary dated January 2025 showed the following:
-Alert and oriented only to person at times;
-Regular pureed diet with thin liquids diet;
-Resident compliant with treatment plan.

Review of the resident's Physician Order Sheet (POS) dated 05/23/25 showed the following:
-Diagnoses of anxiety, weakness, gastric reflux, reduced mobility, heartburn, unsteady on feet, and history of blood clot in the lung;
-Diet changed from mechanical soft consistency (easy to chew foods with finely diced meat) with thin liquids to a regular pureed consistency diet with thin liquids.

Review of the resident's nurses' note dated 02/10/26 at 1:51 P.M., showed the DON documented the resident was in the dining room

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A4777	Continued From page 2	A4777		

eating a snack when she heard the resident start to cough. She checked on the resident and the resident appeared to be coughing up part of his/her snack. The DON encouraged the resident to cough and was getting parts of food out of his/her mouth. At 10:26 A.M., the resident was not clearing any more obstruction and EMS was notified. The resident stopped coughing and only had agonal breaths (abnormal reflexive breathing pattern that occurs when the brain is deprived of oxygen. It is not considered effective breathing and requires immediate medical attention). Staff administered back blows and abdominal thrusts (Heimlich maneuver). Staff laid the resident on the floor and continued to perform the Heimlich maneuver until EMS arrived at 10:32 A.M. At 10:38 A.M. the resident was pronounced deceased.

During an interview on 02/11/26 at 10:45 A.M., Dietary Aide D said the following:
-A written diet list was posted in the kitchen for all staff when preparing and serving meals and snacks;
-The resident was on a pureed diet. The resident's food looked like baby food. He/She used the food processor and added liquids such as water, broth or milk to thin all the resident's food and obtain the pureed texture;
-The resident was the only resident currently on a pureed diet. It was hard for the resident to swallow, he/she ate fast and coughed a lot while eating. All of the resident's snacks should be pureed including bananas. If the resident ate too fast and coughed, he/she stopped eating and raised his/her arms over his/her head to help with swallowing.

During an interview on 02/11/26 at 11:00 A.M., NA A said the following:

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A4777	Continued From page 3 -He/She worked on 02/10/26 in the kitchen as a cook and washed dishes. He/She followed the posted resident diet list in the kitchen when serving meals and snacks. He/She prepared pureed diets in the food processor and added water, broth or milk to make the pureed consistency. Pureed diets looked like baby food. Resident #1's diet was pureed. He/She prepared the resident's food pureed consistency when he/she worked in the kitchen. The resident was a choking risk; -At about 10:00 A.M. he/she passed out snacks. He/She took the resident to the dining room and offered the resident apple sauce. The resident requested a banana. NA A peeled the ripe banana, broke off a piece of the banana and gave it to the resident. (NA A demonstrated with his/her fingers a one-to-two-inch length of banana). The resident choked and coughed up a piece of banana. The DON came to the dining room and was with the resident while NA A went to find NA B for assistance. NA A should have pureed the resident's banana and not given the resident an intact piece of banana. During an interview on 02/11/26 at 11:55 A.M., NA B said the following: -The resident required a pureed diet and ate everything in the consistency of smooth pudding. Staff made pureed diets by blending the resident's food in the food processor and added milk or other liquid to make the pudding like consistency. The resident choked easily and coughed a lot; -He/She was in the shower room on 02/10/26 when NA A said assistance was needed in the dining room. NA B went to the dining room and Resident #1 had choked on a banana. The resident was unresponsive and not breathing. NA B and the DON provided the Heimlich maneuver	A4777		

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A4777	Continued From page 4	A4777		

until EMS arrived;
-Staff should have pureed the banana and not given the resident an intact piece of banana. The resident was not able to swallow foods that were not pureed.

During an interview on 02/11/26 at 12:35 P.M., the DON said the following:
-The resident required a pureed diet and ate all meals and snacks in the dining room. The resident was at risk for choking and required staff supervision while eating. The resident tended to eat fast, coughed frequently and required a pureed diet with thin liquids. Staff should prepare all the resident's food in the food processor into a pureed consistency to prevent choking;
-On 02/10/26, NA A passed snacks about 10:00 A.M. The DON heard the resident coughing from down the hall. She went to the dining room, the resident coughed up a piece of banana then stopped coughing. She called 911 and started the Heimlich Maneuver. The DON and NA B continued the Heimlich maneuver until EMS arrived. The Heimlich maneuver as not successful and the resident expired at 10:38 A.M.;
-Staff were aware of the resident's choking risk and need for a pureed diet. Staff should ensure all the resident's food was pureed to prevent choking including snacks. Staff should have pureed the resident's banana prior to serving the resident the snack.

During an interview on 02/11/26 at 11:45 A.M., Certified Medication Technician (CMT) C said the resident was a choking risk, had a swallowing issue and required a pureed diet. Staff had to keep an eye on the resident while he/she ate. The resident at times tried to take other residents' food that was regular consistency. Staff had to

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A4777	Continued From page 5 monitor for safety while the resident ate. Staff provided the resident apple sauce, yogurt for snacks or something with pureed consistency. Staff should never give the resident a banana or any food that was not pureed. During an interview on 2/11/26 at 12:50 P.M. the Administrator said staff should follow the resident's plan of care, dietary orders and physician orders. Staff should have ensured the resident's snack was pureed. The resident was a known choking risk. *The higher classification merited due to the violation's effect on resident. NOTE: At the time of the complaint investigation, the violation was determined to be at an imminent danger class I level. Based on observation, interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to address and lower the violation. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the Class II level. MO 00260681	A4777		