STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265330	A. Building B. Wing	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Village Park	2041 Silva Lane Moberly, MO 65270

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 36185 Based on interview and record review, the facility failed to ensure one resident (Resident #5), of 14 sampled residents, received necessary care and services in accordance with professional standards of practice. Resident #5 had a left breast needle biopsy (a diagnostic procedure used to investigate masses or lumps) completed on 6/8/23 after a mass was found. The facility failed to follow up and report the biopsy results to the physician until 2/5/24, approximately eight months after the needle biopsy was completed. The biopsy results indicated infiltering duct adenocarcinoma (the most common form of breast cancer and if caught and treated early the survival rate is high). The facility also failed to ensure the resident attended a scheduled follow up appointment with the resident's oncologist to discuss his/her treatment plan.The facility census was 175. Review of the facility's policy, Transcription of Orders/Following Physician Orders, last revised 9/20/23, showed the following: -The purpose of the procedure is to outline procedures in accurately transcribing physician's orders and to ensure that all physicians orders are followed. That a process is in place to monitor nurses in accurately transcribing and following physician orders; -After laboratory testing, diagnostic testing or other services are ordered, the nurse will document orders in residents electronic medical record and fill out the corresponding requisition for the specific services to be obtained (or follow up protocol set forth by individual lab company). The facility policy did not address who was responsible to report laboratory testing or diagnostic testing to the physician. 1. Review of Resident #5's care plan, last updated 5/8/23, showed the following: -The resident had impaired thought process related to schizophrenia, it was difficult to follow his/ her train of thought at times, he/she does have a guardian to assist him/her in major decision making; -The resident is independent with activities of daily living (ADL) but requires assist with personal hygiene, provide protective oversight and assist where needed. Review of the resident's ultrasound of the left breast, dated 5/18/23, showed the following: (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 0684 Level of Harm - Actual harm Residents Affected - Few	-Diagnostic mammogram (x-ray picture) left breast. Ultrasound (a procedure that uses high-energy sound waves to look at tissues and organs inside the body) left breast; -Impression: Suspicious finding for malignancy (cancer). Biopsy should be considered. Review of the resident's Physician's Order Sheet (POS), dated 5/23/23, showed left breast diagnostic, unspecified lump in left breast. Review of the resident's report of consultation (a report that is filled out by the consulting physician following an appointment indicating what was done at the appointment and a copy of the report returns to the facility with the resident), dated 6/8/23, showed the following: -Appointment: breast biopsy; -Diagnosis: breast lump. Review of the resident's physician encounter, progress note, dated 10/2/23 and untimed, showed the following: -The resident had a biopsy of the left breast some time ago and the facility does not have the results; -Mass of the left breast; -Obtain biopsy results. Review of the resident's POS, dated 10/2/23, showed an order to obtain left biopsy results. Review of the resident's left breast pathology report, dated 6/8/23 at 7:29 P.M., reported to the physician on 2/9/24 after the second request, showed the left breast mass, core needle biopsy showed infiltrating duct adenocarcinoma, well differentiated (the tumor cells look more like normal tissue), nuclear grade one out of three (usually means the cancer is slower to grow). Review of the resident's physician encounter progress note, dated 2/9/24, untimed, showed the following: -Type of visit was an add on problem/facility request; -Chief complaint, nature of presenting problem was review of biopsy results; -The resident was seen after requesting left breast biopsy results, I again asked if the facility had results, as no results had been previously noted in the electronic health records. A staff member from the facility in medical records brought the results and it showed infiltrating duct adenocarcinoma of the left breast; -Overall plan, oncology referral regarding left breast adenocarcinoma. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's POS, dated 2/9/24, showed oncology referral regarding left breast adenocarcinoma. Review of the resident's surgical oncology clinic note dated, 3/4/24 at 5:16 P.M., showed the following: -This resident, who resides in a long-term care facility, underwent a needle biopsy of a 7-millimeter (mm) lesion in the upper quadrant of his/her left breast on 6/8/23. This biopsy showed a well-differentiated ductal cancer; -Unfortunately, for some reason the final pathology report did not make it back to the resident's primary physician and so the positive results were just discovered recently. This morning the radiologist noted an abnormal left axillary node (lymph node located in the armpit). The resident presents to clinic this morning to determine the next steps in his/her management; -The resident will need an ultrasound guided core needle biopsy of his/her left axillary nodes as well as a recommended breast magnetic resonance imaging (a non-invasive medical imaging technique the produces three dimensional images of body's internal structures, also called an MRI) of both breasts to determine actual extent of the disease; -Will contact the Director of Nursing (DON) and the resident's physician once the final reports are back. Both are scheduled for 3/8/24. During an interview on 3/14/23 at 3:00 P.M., the resident said he/she had a biopsy of the left breast in June of 2023. He/She did not receive the results of the biopsy from last year. He/She didn't think it was cancer or the facility staff would have told him/her. He/She had a biopsy of the left breast again, last Friday (3/8/24) and the biopsy showed cancer. He/She didn't know what was going to be done to treat the cancer. During an interview on 3/18/24 at 9:15 A.M. the resident's guardian said the following: -She was aware in May of 2023 the resident had some type of mass; -The resident was scheduled to have a biopsy;-She did not hear anything about the biopsy results from last year until last month; -It must have got missed by the facility. The outcome could have been much worse. During an interview on 3/14/24 at 4:14 P.M. the Assistant Director of Nursing (ADON) said the following: -The nursing staff are to follow-up on any biopsy results and to assure those results are sent to the physician in a timely manner; -She found out a couple days ago the resident had cancer in his/her left breast. She was not aware there was a biopsy obtained in June of 2023 of the left breast. During an interview on 3/19/24 at 9:15 A.M. and on 4/2/24 at 10:05 A.M. the DON said the following: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-The facility did not have a current procedure in place for who was responsible for following up on biopsy results and other pathology reports; -Breast cancer could potentially metastasize if left untreated for almost eight months; -She has been working the floor on night shift because the facility is short-staffed, it was hard for her to follow-up on things like this; -The resident was scheduled for a follow-up appointment with oncology for 3/25/24, she notified the appointment scheduler of the appointment and set up transportation. She found out later that the appointment was missed, she was not sure why the appointment was missed; -The appointment was rescheduled; -She had concerns with the system that was in place for scheduling appointments, as there was no reason for the resident's appointment to have been missed. During an interview on 3/14/24 at 3:20 P.M. the Administrator said the following: -He would expect the nursing staff to follow-up on any resident biopsy results and assure those results were sent to the physician in a timely manner; -There was a potential for disease progression or of cancer spreading if biopsy results are not obtained and reported to the physician in a timely manner. During an interview on 3/28/24 at 2:40 P.M. the resident's oncologist said the following: -The resident had a biopsy of a mass on 6/8/23 but the results did not make it back it to the resident's primary physician; -The resident was seen on 3/8/24 in her office for a biopsy and to look at a abnormal lymph node; -Breast cancer left untreated for over eight months could possibly metastasize; -The resident has stage I breast cancer define (considered early-stage, localized cancer and is highly treatable and survivable) and there was no metastasis; -She recommends all her patients who have been diagnosed with breast cancer be scheduled for treatment/surgery within less than two months after cancer is diagnosed ; -The resident was scheduled for a follow-up appointment on 3/25/24 to discuss the lymph node findings and to discuss options for treatment, but the resident did not show up to the appointment scheduled for 3/25/24; -She made multiple phone calls to the facility to inquire why the resident missed the appointment, (there was either no answer or the call went to voicemail) she was finally able to reach facility staff and it was determined the appointment was missed, the appointment was rescheduled; (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-The plan will be for the resident to have have a lumpectomy; -It was possible that delays in having surgery could affect breast cancer outcomes. MO233076

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30813 Based on observation, interview and record review, the facility failed to ensure three residents (Resident #1, #2 and #11), of 14 sampled residents with mental disorders who lived on secured behavioral units, received individualized treatment and services to meet their needs. Residents displayed verbal and physical behaviors on multiple occasions. The facility failed to adequately develop and implement meaningful interventions, including non-pharmacological interventions, alternate strategies, or to ensure the residents received timely and appropriate treatment or services to address the residents' psychosocial well-being. The facility census was 175. Review of the facility's Behavioral Emergency Policy, last revised 1/5/23, showed the following: -The purpose is to provide safe treatment and humane care to the residents in a behavioral crisis, to outline steps to follow to correctly care for the residents in a behavioral crisis and to ensure that the resident is not being coerced, punished or disciplined for staff convenience; -The DON/Assistant Director of Nurses (ADON)/Registered Nurse (RN)/Designee will complete an RN investigation within 24 hours of the behavioral emergency. This may include a PRN (as needed) Intervention Form and notification of state agencies in the event that criteria are met; -In the event that the resident is unable to be redirected or is requesting an as needed (PRN) medication for mood stabilization, the resident will be given PRN medication per physician's orders. If the resident receives a PO (by mouth) PRN mood stabilizing medication, the licensed nurse must complete the PRN Intervention Form. If the resident receives an IM (intramuscular, injection given in the muscle) PRN for mood stabilization a RN Investigation will be completed including the PRN Intervention Form; -The licensed nurse will document the behavioral emergency in the medical record by utilizing the BIRPEEEE documentation guidelines; -B= Behavior Emergency - define behavior -I= Intervention - document intervention, note behavior emergency policy and document interventions from the behavioral emergency policy; -R= Reaction/Response - document reaction and response of the resident after the interventions; -P= Plan - continue current plan of care, continue observing and monitoring of the resident; -E= Evaluation; -E= Evaluation; -E= Evaluation; (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-E= Evaluation; -Documentation of the behavior emergency in the RN Investigation will include evaluation of the resident's behavior, including consideration for precipitating events or environmental triggers, and other related factors in the medical record with enough specific detail of the actual situation to permit underlying cause identification to the extent possible, not identifying or attempting to identify the root causes of the behaviors and not revising the plan of care with measurable goals and interventions to address the care and treatment for a resident with behavioral and/or mental/psychosocial -All Behavioral Emergency Code [NAME] Reviews filled out by the responding staff will become part of the RN investigation to ensure that the behavioral crisis was handled professionally, that it could not have been avoided, and was handled by CALM certified staff using appropriate techniques, following policies of the facility. -Following the Behavioral Emergency Policy is vital and all areas that the Behavioral Emergency Policy addresses must be clearly understood and documented. 1. Review of Resident #1's PASARR (Pre-Admission and Resident Review)/Mental Illness Level II Evaluation, dated 3/8/17, showed the following: -His/Her diagnoses included bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels and concentration), obsessive compulsive disorder (OCD, disorder in which a person experiences uncontrollable and recurring thoughts (obsessions), engages in repetitive behaviors (compulsions), or both), attention deficit hyperactivity disorder (ADHD, differences in brain development and brain activity that affect attention, the ability to sit still, and self-control), Asperger's syndrome (a development disorder), adjustment disorder (excessive reactions to stress that involve negative thoughts, strong emotions and changes in behavior), and polysubstance abuse disorder (the consumption of more than one drug at once); -He/She was previously admitted to a behavioral health facility in September 2016; -He/She had been discharged from many placements due to behaviors; -Prior to this admission, he/she was living with family. He/She became angry, attempted to attack a family member and the family member called the police; -He/She obtained a knife and threatened to cut his/her wrists, then chased another family member around the house with the knife; -He/She continues to demonstrate acting out behaviors, shows bravado (a show of boldness intended to impress or intimidate) to peers, is sarcastic and insulting to peers using racial slurs at times; (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She displays about one episode per day of agitation, usually at shift change, when he/she will hit the walls, throw his/her plastic water mug, and is verbally aggressive to peers and staff; -He/She reported to curse, be demanding, express paranoid ideation regarding others being out to get him/her and believes his/her family is against him/her; -He/She is often attention-seeking and will agitate/offend peers by his/her behaviors and insults; -He/She shows poor attendance to group activities and sleeps late; -Current psychiatric support/services: medication therapy, administration and monitoring; inpatient psychiatric treatment; community support services and locked inpatient psychiatric unit with close observation/check every 15 minutes; -He/She was alert and oriented to person, place, time and situation; -He/She was coherent, had poor concentration and poor judgement, was incoherent/illogical, had loose associations and poor insight; -He/She did not make good decisions, follow complex directions or stay on task/complete assignments; -He/She refuses activities, refuses to eat, is impatient/demanding, has history of alcohol/drug use, curses/swears, disturbs other residents, is physically threatening, suspicious of others, makes suicide threats and paces, frequently yells/continuously yells, is verbally abusive and threatening and has history of being physically aggressive towards family members; -When he/she wants increased attention, he/she is insulting to peers and argumentative; -He/She can be polite with peers and staff but generally has some conflict with peers on a daily basis. He/She uses racial slurs. Staff reported the resident tends to keep things bottled up then loses control of his/her anger; -Symptoms include periods of severe agitation, property destruction, verbal/physical aggression, irritability, mood lability, depressed mood with threats to harm self, impulsivity, anger, outbursts, severely impaired judgement/insight/concentration. Has lengthy history of psychiatric treatment dating to age three; -He/She has had the following changes in the last six months: difficulty interacting appropriately/communicating effectively with others; a history of altercations, evictions, firing, fear of strangers; avoids interpersonal relationships; is socially isolated; has difficulty concentrating; has difficulty in sustaining focused attention to complete common tasks; has difficulty in adapting to typical changes associated with work, family or social interaction; manifests agitation, exacerbated signs and symptoms associated with the illness; and withdraws from the situation; -He/She requires 24 hour per day monitoring due to self harm behaviors and severely impaired judgement related to mental illness; (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She requires staff to set up/administer medications due to impaired judgement and past history of polysubstance abuse; -He/She requires ongoing professional assessment of mood, behavior, thought process, and risk for harm to self or others. Monitor carefully for increased motor activity as predicator of agitation/assault; -If admitted to a nursing facility, the individual may benefit from the following additional services: secured unit/facility, recreational therapy/activities evaluation, individual counseling/psychotherapy, grief/loss/adjustment/emotional support and medication education/counseling; -Summary: he/she has a history of psychiatric treatment dating to age three. He/She has limited intellectual abilities and autism spectrum disorder, which complicates his/her functional status. He/She has had repeated hospitalization s for physical and verbal aggression and threats of harming self. He/She has attacked family members on more than one occasion and has made threats to harm self when angry. He/She is in need of long-term, structured and secured placement to assure he/she has consistent access to psychotropic medications and psychiatric treatment. He/She is at risk of harming self and others if he/she is not in structured placement. Review of the resident's face sheet showed he/she admitted to the facility on [DATE]. Review of the resident's care plan dated 8/1/23, showed the following: -Triggers: being misunderstood and being bullied; -Coping skills: walking away, listening to music and gaming; -Evaluate verbal expressions of fear; -Provide reassurance to resident/representative; -Encourage use of PRN medication to alleviate symptoms; -Evaluate for cause of fear or anxiety; -Explain all procedures as appropriate, using simple, concrete terms; -Monitor for presence of negative thoughts and feelings. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by facility staff, dated 10/26/23, showed the following: -Cognitively intact; -He/She had inattention and disorganized thinking that fluctuated; -He/She had delusions; (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She had verbal behaviors one to three days of the seven day look back period; -He/She had behaviors not directed at others one to three days of the seven day look back period; -He/She wandered one to three days of the seven day look back period; -He/She received antipsychotic and antidepressant medications. Review of the resident's psychosocial note, dated 12/14/23, showed the following: -The resident had increased anxiety and depression symptoms; -He/She lacks focus and concentration; -He/She had difficulty responding to generalized and/or open-ended questions; -Impaired insight and judgement as evidenced by decisions of recent past; -Mental status exam: no change; -Assessment plan: diagnosis of adjustment disorder with mixed anxiety and depression with new order for Paxil (used to treat depression and anxiety) 10 milligrams (mg) by mouth (PO) daily. Review of the resident's Physician Order Sheet (POS), showed the following: -On 12/19/23, new order for Paxil 10 mg PO daily; -On 1/12/24, new order for Buspar (used to treat anxiety) 5 mg PO three times daily (TID). Review of the resident's nurses notes showed the following: -On 1/18/24 at 4:34 P.M., the resident was being verbally inappropriate, seemed agitated and reports another resident was calling him/her a snitch. The resident was re-educated on consequences and how to use coping skills. The resident was able to calm down and was no longer verbally inappropriate; -On 1/18/24 at 6:17 P.M., the resident was being verbally aggressive towards kitchen staff and when nursing tried to redirect him/her, the resident began cursing at this nurse. Code green was called and the resident went back to his/her hall. Administration arrived and took over the code. The resident was able to be redirected using coping skills and educated on using proper healthy communication. Long-Term Care Psychiatry (LTCP), the resident's primary care physician (PCP), assistant director of nursing (ADON), administrator and guardian all made aware; -On 1/24/24 at 7:16 P.M., staff sent a counseling consent form to the guardian for review, signature and consent; (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 1/31/24 at 2:44 P.M., Code [NAME] called and when staff arrived on the unit, it was reported to this nurse the resident was kicking doors and punching walls. When this nurse asked the resident what was wrong, he/she said he/she was agitated. The resident then went back to his/her room, administration arrived and took over the code. LTCP, DON, PCP and guardian all notified; -On 2/1/24 at 6:01 A.M., this writer met with the resident regarding his/her code green on 1/31/24. Resident said he/she was frustrated his/her family can't come for a visit. This writer spoke with resident about his/her coping skills and resident agreed to communicate with staff when agitated; -On 2/7/24 at 11:09 P.M., it was reported to staff that the resident was punching the wall in the common area. He/She stopped and talked with staff. He/She thought his/her hand was broken. Right hand swollen and knuckles are red. Can move fingers. Notified guardian, administration, DON, LTCP and PCP. (Review showed no evidence the facility attempted to identify the root cause of the resident's behavior and no evidence the resident did or did not have a fractured hand); -On 2/16/24 at 7:31 P.M., the resident was pacing halls mumbling inappropriate comments to staff. Code [NAME] called, allowed time with administration to discuss feelings and appropriate behaviors. The resident was able to be redirected. He/She was currently calm with no further behaviors noted. DON, guardian, administration, PCP and LTCP aware. (Review showed no evidence the facility attempted to identify the root cause of the resident's behavior); -On 3/2/24 at 5:36 P.M., Code [NAME] called when the resident punched a hole in the wall of his/her unit. The resident then went to his/her room to lay down in bed. The resident said staff accidentally handed out his/her personal cigarettes to a different resident. The resident said he/she overreacted and was almost immediately apologetic. Staff talked with resident about his/her feelings as a positive coping skill. DON, administration, PCP, LTCP made aware; -On 3/2/24 at 10:55 P.M., it was reported this resident's cigarettes were missing. Environmental and room checks initiated. The resident felt agitated and had thoughts of hurting others. This nurse encouraged him/her to utilize coping skills but these were not effective. Notified the assistant administrator (AA) and DON. Gave as needed (PRN) hydroxyzine (for anxiety) by mouth. Guardian made aware. At 10:58 LTCP notified; -On 3/2/24 at 11:56 P.M., the resident verbalized he/she had thoughts of hurting others due to increased aggression. The resident denies hurting self and requesting PRN. PRN effective and resident was calm and cooperative. Will continue to monitor behavior; -On 3/5/24 at 7:22 P.M., it was reported to this nurse that the resident was punching walls. Another resident allegedly was verbally aggressive and the other resident punched Resident #1 on the left side of the jaw/neck area. Code [NAME] called. The residents were immediately separated. The resident deescalated by talking one-on-one. Peer was moved to a different hall. Notified administration, DON, LTCP and left message for guardian; -On 3/5/24 at 8:30 P.M., according to resident's and peer's statements, the resident was cursing and yelling at peer, words were exchanged. The words were more along the line of attention seeking by peer; (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 3/6/24 at 11:25 A.M., administration met with the resident for feelings and concerns regarding the incident with peer on 3/5/24. The resident said he/she was not mad at peer and never really had an issue with the peer. He/She wasn't in any kind of pain as a result of the incident and that he/she felt safe. The resident said he/she had no issue with peer and was able to apologize to peer and shake hands and agree to move past the incident. The resident also was willing to enter into a behavior contract with the peer. This administrator also educated resident that if he/she was frustrated to use coping skills or talk with staff. The resident was also educated that he/she could utilize the punching bag. The resident was agreeable to education. Review of the resident's care plan updated on 3/6/24, showed interventions including immediate separation, neuro checks, code green called, skin assessment with no injuries, medication administration records (MAR), treatment administration records (TAR) and labs reviewed. LTCP review of medications, resident focus interviews daily, education on using coping skill, education on letting staff handle peers, education to using punching bag when frustrated, electronic medical record (EMR) updated that resident can use punching bag anytime, behavior contract. Notify administration, DON, guardian, police department, PCP, LTCP and management. Review of the resident's nurses notes showed the following: -On 3/9/24 at 4:09 P.M., it was reported to this nurse that resident was hit by a peer. The resident said he/she pieced the peer up. The residents were immediately separated. Notified administration, DON, PCP, LTCP and left a message for the guardian. (Review showed no evidence the facility attempted to identify the root cause of the resident's behavior); -On 3/9/24 at 9:14 P.M., it was reported to this nurse the resident returned to the hall after coming back from the Hangout (a common area for residents to gather and socialize). Peer (Resident #2) at this point began to antagonize the resident yelling through the locked door separating the hallways. It was reported that peer (Resident #2) was yelling that the resident was a snitch. This upset the resident and he/she began to pace up and down the halls, punching walls. Certified Medication Technician (CMT) was with the resident attempting to de-escalate him/her. The resident kicked the locked door separating 200 and 300 hall, and staff yelled to call a Code Green. As staff went to call code, the peer (Resident #2) broke through locked door, went to the resident and then became physically aggressive towards the resident. The resident defended himself/herself towards peer (Resident #2). The resident said he/she pieced that up. Code [NAME] called, and the residents were immediately separated. Peer (Resident #2) was removed from area and taken back to 300 hall. The resident was taken to the nurse's station where vital signs were taken and within normal limits (WNL). Skin assessment completed with no injuries noted and neuro checks started which were also within normal limits. DON, Administration, LTCP, PCP, and guardian notified; -On 3/10/24 1:26 P.M., met with this resident today. He/She was a little agitated. Discussed using his/her coping skills so he/she turned on some music. The resident denied any thoughts of suicidal ideations (SI), homicidal ideation (HI) or elopement ideation (EI). Will continue to monitor; -On 3/10/24 at 3:39 P.M., the resident was hitting walls, cursing in the hallway at staff, disrupting other residents, and slamming the fire doors shut. He/She was upset because he/she was suspended from the Hangout (due to the incident on the previous day). He/She was able to talk to staff and calm down. Notified administration, DON, PCP, LTCP and guardian. Will continue to monitor; (continued on next page)

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	265330	A. Building B. Wing	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Village Park	2041 Silva Lane Moberly, MO 65270

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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 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 3/11/24 at 1:15 P.M., the Social Services Director (SSD) and the administrator met with the resident regarding the altercation that the resident was involved in with a peer (Resident #2). The resident was allowed to vent his/her frustrations about his/her peer. The resident said the peer had been aggravating him/her by calling him/her a snitch. The resident denied snitching on his/her peers and did not know what they were talking about. The resident was educated on reporting things to staff when he/she becomes agitated or upset with his/her peers and utilizing coping skills. The resident said he/she understood. This writer asked the resident if he/she had any further issues with his/her peer, the resident said no and that he/she wants to continue living on a separate unit. The resident said he/she does not want to have any communication with his/her peer, he/she has agreed to leave his/her peer alone. The resident denied SI, HI or EI. He/She also denied agitation/aggression. Will continue to monitor. Review of the resident's care plan, last reviewed 3/12/24, showed the following: -On 3/12/24, daily resident focus interviews. Set up to see LTCP. Will try to set up a behavior contract between both residents when both are agreeable. Resident #2 willing to establish contract, but Resident #1 does not want to at this time. He/She prefers to just avoid Resident #2. Educated on using coping skills when agitated with peers. Both residents separated and skin assessments completed with no injuries. Resident #1 started on neuro checks due to being hit above the neck. Resident #2 placed on one-on-one monitoring. No PRN needed. Both residents already reside on separate halls. Guardian, PCP, LTCP, police department, State Agency (SA) and management all notified; -No evidence facility staff evaluated current interventions or implemented new interventions after the resident had behaviors on 1/18/24, 1/31/24, 2/7/24, 2/16/24, 3/2/24, or 3/5/24. Review of the resident's electronic medical record (EMR) showed no evidence the counseling request sent to the resident's guardian on 1/24/24 had been returned, counseling had been scheduled, or evidence the resident had seen LTCP since 12/14/23. During interview on 3/13/24 at 9:53 A.M., Resident #1 said he/she didn't do anything to Resident #2 (on 3/9/24). Resident #2 busted through the 300 hall door and hit him/her in the head with a closed fist. He/She hit Resident #2 back in self-defense. Resident #2 had called him/her a snitch and kept harassing him/her. He/She had issues with Resident #2 in the past. He/She had been kicking the walls because Resident #2 was calling him/her a snitch. He/She denied being a snitch. He/She has a signed agreement not to have issues with Resident #2. He/She has only seen psych once since admission. 2. Review of Resident #2's PASARR, dated 9/1/15, showed the following: (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-His/Her diagnoses included schizoaffective disorder, bipolar, history of pyromania (type of impulse disorder that is characterized by being unable to resist starting fires), encopresis (the repeated passing of stool into clothing), attention deficit hyperactivity disorder (ADHD), generalized anxiety disorder, oppositional defiant disorder (ODD, marked by defiant and disobedient behavior to authority figures), major depressive disorder, intermittent explosive disorder (repeated, sudden bouts of impulsive, aggressive, violent behavior or angry verbal outbursts), conduct disorder (a group of behavioral and emotional problems characterized by a disregard for others), substance use, post traumatic stress disorder (PTSD, a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event), paranoid personality disorder (a mental health condition marked by a long-term pattern of distrust and suspicion of others without adequate reason to be suspicious), mild intellectual disability, learning disability and history of antisocial traits, traumatic brain injury (TBI) at age five; -His/Her first treatment listed at age seven years old. He/She is listed with diagnosis of learning disorder on 9/9/03. He/She has had multiple head injuries as a child with a TBI at age five. There is a history of neglect and abuse with academic underachievement treatment failures. He/She was in special education and dropped out of school in the sixth grade. He/She was in juvenile detention five to six times. Has a reported history of mood swings, irritability, self-harm, poor impulse control and poor judgement; -Inpatient hospitalization s numerous times for behavioral issues, suicide attempts and homicidal threats; -He/She was alert and oriented to person, place, time and situation; -He/She had poor concentration, poor judgement, loose associations, problems with abstraction, tangential, long-term memory deficit and poor insight; -He/She could not follow complex directions or stay on task/complete assignments; -He/She is childlike, easily frustrated, easily distracted, impatient/demanding, disturbs other residents and curses/swears; -He/She has mild auditory and visual hallucinations; -Guardian has a placement for the resident to a facility specific to his/her psychiatric needs; -Short-term nursing facility level of service recommended; -He/She needed drug therapy and monitoring of drug therapy, training in drug therapy management, structured socialization activities to diminish tendencies toward isolation and withdrawal, development and maintenance of necessary activities of daily living, development of appropriate personal support networks, implementation of systematic plans to change inappropriate behavior, provision of a structured environment, physician services, social work services, guardianship, secured unit, art/music therapy. Review of the resident's face sheet showed he/she admitted to the facility on [DATE]. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's care plan, dated 10/12/23, showed the following: -The resident has a behavior problem with verbal and physical aggression related to depression and schizophrenia; -Administer medications as ordered; -Anticipate and meet the resident's needs; -If reasonable, discuss the resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident; -Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation and take to alternative location as needed; -Resident can be physically aggressive towards peers; -Behaviors: agitation and anxiety. If you see resident exhibiting any behaviors listed in this section, refer to preferred coping skills and redirect behavior immediately; -Coping skills: taking a walk and talking to his/her family member; -If resident is having behaviors and preferred coping skills are found to be NOT effective, refer to CALM de-escalation protocols; -If staff observes a trigger happening to the resident, immediately refer to the resident's preferred coping skills and redirect behavior; -If you see resident exhibiting any behaviors listed in the current behaviors section, refer to preferred coping skills immediately; -Triggers: raising your voice. Review of the resident's psychosocial notes, dated 12/16/23, showed the following: -Resident seen today for follow up visit of sleep, mood, anxiety, delusions and medication reconciliation; -Symptoms: night terrors- will increase prazosin (medication used to treat night terrors from post traumatic stress disorder), increased agitation, verbal altercation, increased anxiety; -Trouble falling asleep, loss of energy/motivation, difficulty starting tasks, diminished pleasure from daily activity; -Had difficulty responding to generalized and/or open-ended questions; -Confused, inattentive; (continued on next page)

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