

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265330	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2024
NAME OF PROVIDER OR SUPPLIER North Village Park		STREET ADDRESS, CITY, STATE, ZIP CODE 2041 Silva Lane Moberly, MO 65270	
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)		
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42594</p> <p>Based on interview and record review, the facility failed to ensure one resident (Resident #2) in a review of 13 sampled residents, who was monitored one on one by Certified Nurse Aide (CNA) F, was free from abuse when Resident #1 entered Resident #2's room and started a verbal argument. The verbal argument escalated and CNA F did not intervene. Resident #1 hit Resident #2 in the head and neck repeatedly with a closed fist which resulted in the resident being sent to the hospital where he/she was diagnosed with a neck contusion (bruising). Resident #2 remained fearful and scared of Resident #1 and was moved to another hall for his/her safety. The facility census was 178.</p> <p>Review of the facility Abuse and Neglect policy, dated 6/12/24, showed the following:</p> <ul style="list-style-type: none"> -Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations; -Physical abuse is purposefully beating, striking, wounding, or injuring any resident in any manner whatsoever mistreating or maltreating a resident in a brutal or inhumane manner; -Physical abuse also includes but is not limited to hitting, slapping, punching, biting and kicking; -The facility will develop and operationalize policies and procedures for screening and training employees, protection of residents and for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, and misappropriation of property; -The purpose is to assure that the facility is doing all that is within its control to prevent occurrences; -New employees will be educated by the department manager or designee on issues related to abuse prohibition practices during initial orientation and annually; -The facility will identify, correct and intervene in situations in which abuse, neglect and/or misappropriation of resident property is more likely to occur; <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 265330
		If continuation sheet Page 1 of 20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265330	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2024
NAME OF PROVIDER OR SUPPLIER North Village Park		STREET ADDRESS, CITY, STATE, ZIP CODE 2041 Silva Lane Moberly, MO 65270	
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)		
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-During orientation of new employees, the facility will cover at least the following topics: Sensitivity to resident rights and resident needs and what constitutes physical, sexual, verbal and mental abuse, and how to assess, prevent and manage aggressive, violent, and/or catastrophic reactions of residents in a way that protects both residents and staff;</p> <p>-Residents who allegedly mistreat another resident will be removed from contact with the resident during the course of the investigation. The accused resident's condition shall be immediately evaluated to determine the most suitable therapy, care approaches, and placement considering his/her safety, as well as the safety of other residents in the facility.</p> <p>1. Review of the facility Administrative/Registered Nurse Investigation, dated 7/15/24, showed the following:</p> <p>-Date of incident was 7/15/24;</p> <p>-Type of incident; physical aggression involving the head;</p> <p>-Person(s) involved in the incident: Resident #1, #2, #3, and #12;</p> <p>-There was a physical altercation between Resident #1 and #2;</p> <p>-Certified Nurse Aide (CNA) F was one-on-one with Resident #2 when Resident #1 came into Resident #2's room yelling;</p> <p>-CNA F said he/she tried to redirect Residents #1, #3, and #12;</p> <p>-Hall Monitor I heard the commotion and went to Resident #2's room and tried to redirect Resident #1;</p> <p>-Resident #1 pushed past Hall Monitor I and struck Resident #2 with a closed fist;</p> <p>-The facility concluded Resident #1 did strike Resident #2 with a closed fist;</p> <p>-The facility concluded Resident #1 had diagnoses of oppositional defiant disorder and intellectual disabilities with a history per his/her Preadmission Screening and Resident Review (PASARR, a federally mandated screening process for individuals with serious mental illness and/or intellectual disability/developmental disability related diagnosis) of poor impulse control. When Resident #1 heard that Resident #2 made negative comments about Resident #12, Resident #1 responded by striking Resident #2;</p> <p>-Resident #2 complained of pain in the head and was sent to the hospital for evaluation. Resident #2 returned from the hospital with a diagnosis of a neck contusion (bruising).</p> <p>2. Review of Resident #1's care plan, dated 9/25/23, showed the following:</p> <p>-Special Instructions: High behavior resident/resident behaviors: physical aggression towards others, assaultive behaviors, biting others and anger management. Effective coping skills included coloring and listening to music;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265330	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2024
NAME OF PROVIDER OR SUPPLIER North Village Park		STREET ADDRESS, CITY, STATE, ZIP CODE 2041 Silva Lane Moberly, MO 65270	
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)		
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-The resident was at risk for altercation in mood and delusional thought process related to bipolar disorder (a mental illness that causes extreme mood swings that include emotional highs and lows);</p> <p>-Monitor for changes in mood and behaviors, provide a calm environment and redirect as needed;</p> <p>-The resident had a history of behaviors related to his/her mental health including verbal aggression, emotional disturbances, poor impulse control, aggressiveness, combative behaviors, poor judgement, intrusive, anger management, poor social skills, homicidal ideations, assaultive behaviors, auditory and visual hallucinations, poor boundaries with others and was child-like (functions at the level of a [AGE] year old);</p> <p>-The resident had a history of behavioral challenges that required protective oversight in a secure setting that included physically aggressive, threatening behavior, verbally aggressive, and poor impulse control;</p> <p>-The resident had a history of post-traumatic stress disorder (PTSD, a psychiatric disorder that may occur in people who have experienced or witnessed a traumatic event, series of events or set of circumstances.</p> <p>-Assess the resident for suicidal or homicidal ideations to ensure the safety of the resident and others;</p> <p>-Remain with the resident at all times when levels of anxiety are high.</p> <p>Review of the resident's care plan, dated 5/6/24, showed the resident returned to the facility from jail after assaulting a staff member.</p> <p>Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by facility staff, dated 6/16/24, showed the following:</p> <p>-The resident was cognitively intact;</p> <p>-The resident had diagnoses that included medically complex conditions, depression, oppositional defiant disorder (ODD, a type of disruptive behavior disorder in which people frequently defy authority with hostility, leading to serious disturbances in their daily life), bipolar disorder, intellectual disabilities (ID, a term used when a person has certain limitations in cognitive functioning and skills, including conceptual, social and practical skills, such as language, social and self-care skills) and mood disorder (mental conditions characterized by persistent disturbance of mood, especially in the form of depression or euphoria or a combination of these).</p> <p>Review of Resident #1's facility acquired written statement, dated 7/15/24, showed the following:</p> <p>-Resident #1 said he/she was told Resident #2 talked bad about Resident #12 who was Resident #1's friend. That upset Resident #1;</p> <p>-Resident #1 went to Resident #2's room and yelled at him/her and told Resident #2 to stop talking about Resident #12;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265330	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2024
NAME OF PROVIDER OR SUPPLIER North Village Park		STREET ADDRESS, CITY, STATE, ZIP CODE 2041 Silva Lane Moberly, MO 65270	
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)		
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-Resident #1 said he/she hit Resident #2 a few times in the head area and walked out of the room;</p> <p>-A code green (a code called when a behavioral event occurs and trained staff respond to assist to deescalate a situation) was called, and Resident #1 did not remember who was in the room, it all happened fast.</p> <p>During an interview on 7/29/24 at 12:17 P.M., the resident said the following:</p> <p>-Resident #3 told him/her Resident #2 talked bad about Resident #12;</p> <p>-Resident #1 did not like people talking bad about his/her friends and it made him/her mad;</p> <p>-Resident #1 went to Resident #2's room and they argued;</p> <p>-Resident #1 threw Resident #2's blankets at Resident #2 and then Resident #1 hit Resident #2;</p> <p>-Hall Monitor I came in the room and separated the two residents;</p> <p>-Resident #2's one-on-one staff (CNA F) was in the room at the time, but he/she did not do anything or say anything.</p> <p>2. Review of Resident #2's care plan, dated 9/20/23, showed the resident had a history of behavioral challenges that required protective oversight in a secure setting.</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed the following:</p> <p>-The resident was cognitively intact;</p> <p>-The resident had diagnoses that included anxiety, depression, borderline personality disorder (a mental health condition that affects the way people feel about themselves and others, making it hard to function in everyday life. It includes a pattern of unstable, intense relationships, as well as impulsiveness and an unhealthy way of seeing themselves. Impulsiveness involves having extreme emotions and acting or doing things without thinking about them first), and schizophrenia (a chronic mental disorder characterized by delusions, hallucinations, disorganized speech and behavior, and decreased emotional expression and motivation);</p> <p>-The resident did not have any behaviors.</p> <p>Review of the resident's progress notes, dated 7/15/24, showed the following:</p> <p>-At 4:25 P.M. the resident told staff he/she felt suicidal and was immediately placed on one-on-one with staff;</p> <p>-At 8:15 P.M. the resident was one-on-one with staff when a peer entered his/her room and became verbally abusive and punched the resident in the head.</p> <p>Review of the resident's facility acquired written statement, dated 7/15/24, showed the following:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265330	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2024
NAME OF PROVIDER OR SUPPLIER North Village Park		STREET ADDRESS, CITY, STATE, ZIP CODE 2041 Silva Lane Moberly, MO 65270	
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)		
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-Resident #1 went into Resident #2's room and told him/her to stop talking about Resident #12;</p> <p>-Resident #2 told Resident #1 it was none of his/her business and to leave the room;</p> <p>-Resident #1 did not leave Resident #2's room even after being asked a second time by Resident #2;</p> <p>-A staff member came into Resident #2's room and stood between Resident #1 and #2;</p> <p>-Resident #1 went around the staff member and started hitting Resident #2 in the head. Resident #1 hit Resident #2 six times in the head;</p> <p>-Staff got between the two residents and Resident #1 left the room.</p> <p>During an interview on 7/24/24 at 9:18 A.M. and 7/29/24 at 11:18 A.M., the resident said the following:</p> <p>-Resident #1 came into his/her room and asked why he/she was talking about Resident #12;</p> <p>-He/She and Resident #1 argued and yelled at each other;</p> <p>-He/She asked Resident #1 to leave his/her room, but Resident #1 did not leave;</p> <p>-Resident #1 hit Resident #2 in the head and neck six times;</p> <p>-Resident #12, #3, and another peer blocked the doorway so Resident #2's one-on-one staff could not get out</p> <p>-CNA F did not do anything at all to help the resident when Resident #1 came in his/her room;</p> <p>-He/She had trouble sleeping since the incident with Resident #1 and was supposed to get moved to another room, because he/she just didn't feel safe around Resident #1.</p> <p>Review of the resident's hospital discharge records, dated 7/15/24, showed the following:</p> <p>-The resident was discharged to the facility on [DATE];</p> <p>-The resident had a neck contusion.</p> <p>During an interview on 8/1/24 at 9:50 A.M. Resident #2's guardian said the following:</p> <p>-She went to the facility the day of the altercation between Resident #1 and #2;</p> <p>-She filed charges with the police department because this was not the first incident with Resident #1;</p> <p>-Resident #2 was moved to another hall on 7/29/24 because he/she was scared of Resident #1 even though Resident #1 was on one-on-one supervision.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265330	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2024
NAME OF PROVIDER OR SUPPLIER North Village Park		STREET ADDRESS, CITY, STATE, ZIP CODE 2041 Silva Lane Moberly, MO 65270	

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)
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 7/25/24 at 8:30 A.M., CNA F said the following:</p> <ul style="list-style-type: none"> -He/She was hired around July 1, 2024; -He/She did not get any training about being one-on-one with residents or how to handle physical aggression by residents; -He/She was one-on-one with Resident #2 on 7/15/24; -He/She did not intervene or get in between Resident #1 and Resident #2; -CNA F said he/she was not going to get in the middle of all that mess; -He/She went to get someone to help and Resident #12 was blocking the doorway; -Another staff was across the hall and came to help. <p>During an interview on 7/30/24 at 2:57 P.M., Hall Monitor I said the following:</p> <ul style="list-style-type: none"> -Hall Monitor I was across the hall from Resident #2's room with another resident when he/she heard yelling and arguing; -Hall Monitor I went to Resident #2's room and saw Resident #1 and #2 arguing with each other; -CNA F was in the room just standing there watching and doing nothing; -Hall Monitor I tried to calm Resident #1, but the resident went around him/her and started hitting Resident #2 in the head; -Other residents were in the hallway outside Resident #2's room but none of them were blocking the doorway. <p>During an interview on 7/24/24 at 3:33 P.M., 7/29/24 at 5:38 P.M. and 8/1/24 at 1:31 P.M., the Administrator said the following:</p> <ul style="list-style-type: none"> -He would expect one-on-one staff to intervene in any verbally or physically aggressive situation; -Staff should protect the residents; -CNA F would have had training during orientation that would have covered one-on-one supervision situations, abuse and neglect, intervening when needed and resident to resident altercations. -Resident #2 was moved to another hall to keep him/her away from Resident #1 and to help Resident #2 feel safe. -The facility concluded Resident #1 hit Resident #2 and this was considered abuse by Resident #1. <p>MO239016</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265330	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2024
NAME OF PROVIDER OR SUPPLIER North Village Park		STREET ADDRESS, CITY, STATE, ZIP CODE 2041 Silva Lane Moberly, MO 65270	
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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42594</p> <p>Based on interview and record review, the facility failed to provide protective oversight for one resident (Resident # 3) with psychiatric diagnoses, and a history of suicidal ideation, who lived on a secured behavioral unit, when the resident obtained a disposable razor on 7/23/24 from another resident (Resident #8) and cut his/her wrist several times. The facility census was 178.</p> <p>The Administrator was notified on 7/24/24 at 2:45 P.M. of the Immediate Jeopardy (IJ), which began on 7/23/24. The IJ was removed on 7/25/24, as confirmed by surveyor onsite verification.</p> <p>Review of the facility's Behavioral Emergency Policy, dated 6/26/24, showed the following:</p> <ul style="list-style-type: none"> -It is the policy of the facility to provide a safe environment and provide humane care to all residents; -Care will be guided by the resident's plan of care and based on the strategies taught by Crisis Prevention Institute non-violent crisis intervention, or the current company guidance, and will help to respond to difficult behaviors in the safest and most effective way possible. <p>The facility did not have a policy specific to the use of razors by residents, how staff were to handle/dispose of resident razors, or how staff were to ensure razors were accounted for/safely managed.</p> <p>1. Review of Resident #3's Preadmission Screening and Resident Review (PASARR, a federally mandated screening process for individuals with serious mental illness and/or intellectual disability/developmental disability related diagnosis), dated 1/18/22, showed the following:</p> <ul style="list-style-type: none"> -The resident had a history of abuse and neglect by his/her parents and an unstable childhood; -The resident had current diagnoses that included bipolar disorder (causes extreme mood swings that include emotional highs and lows), schizoaffective disorder (a combination of symptoms of schizophrenia, a serious mental illness that affects how a person thinks, feels, and behaves, and mood disorder, such as depression), borderline personality disorder (a mental health condition that affects the way people feel about themselves and others, making it hard to function in everyday life. It includes a pattern of unstable, intense relationships, as well as impulsiveness and an unhealthy way of seeing themselves. Impulsiveness involves having extreme emotions and acting or doing things without thinking about them first), post-traumatic stress disorder (PTSD, a mental health condition that's triggered by a terrifying event, either experiencing it or witnessing it), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest); -The resident had a history of being involved in satanic cult ceremonies which he/she was the recipient of multiple lacerations by religious knives; <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265330	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2024
NAME OF PROVIDER OR SUPPLIER North Village Park		STREET ADDRESS, CITY, STATE, ZIP CODE 2041 Silva Lane Moberly, MO 65270	
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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-The resident had historical behaviors of suicidal ideations, depression, impulsiveness, poor judgement and insight, impulsive suicidal act, feelings of hopelessness and helplessness, and auditory and visual hallucinations;</p> <p>-At the time of the evaluation the resident had superficial lacerations to his/her left forearm, left bicep and across his/her anterior neck;</p> <p>-The resident had a history of cutting himself/herself with an onset at age 13.</p> <p>Review of the resident's care plan, dated 8/22/22, showed the following:</p> <p>-The resident had current behaviors that included anxiety, poor impulse control, poor judgement, verbal and physical aggression, racing thoughts, abnormal thought process, suicide ideation/attempt, self-harm and poor boundaries;</p> <p>-The resident did not always think about the consequences before he/she acted and acted on impulse without thinking about his/her safety.</p> <p>Review of the resident's care plan, dated 2/6/23, showed the following:</p> <p>-The resident had a behavior problem related to bipolar disorder;</p> <p>-Monitor behavior episodes and attempt to determine the underlying cause.</p> <p>Review of the resident's care plan, dated 4/30/23, showed the following:</p> <p>-The resident's PASARR showed the resident had a history of abuse and neglect by family, and a history of behavioral challenges that required protective oversight in a secure setting;</p> <p>-Current behaviors were anxiety, depression, agitation, poor impulse control, poor judgement and mania.</p> <p>Review of the resident's care plan, dated 6/26/23, showed behavior per the resident's PASARR showed suicidal ideations, depression, labile (something that can change quickly and spontaneously) and impulsive.</p> <p>Review of the resident's care plan, dated 11/21/23, showed the following:</p> <p>-The resident was at risk for lack of motivation, interest and self-harm related to a history of suicidal ideation;</p> <p>-Implement safety measures;</p> <p>-Provide education and support;</p> <p>-Monitor for suicidal and homicidal ideations.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265330	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2024
NAME OF PROVIDER OR SUPPLIER North Village Park		STREET ADDRESS, CITY, STATE, ZIP CODE 2041 Silva Lane Moberly, MO 65270	
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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the resident's quarterly Minimum Data Set (MDS, a federally mandated assessment instrument required to be completed by facility staff), dated 5/24/24, showed the following:</p> <ul style="list-style-type: none"> -The resident admitted to the facility on [DATE]; -The resident was cognitively intact; -The resident had diagnoses that included medically complex conditions, schizophrenia and bipolar disorder. <p>During an interview on 7/24/24 at 9:27 A.M., Resident #8 said the following:</p> <ul style="list-style-type: none"> -He/She had a razor in his/her room for about three or four weeks; -He/She got the razor when showering and there was no staff to give it back to, so he/she took it to his/her room and continued to use it; -Resident #3 asked if he/she could use the razor to shave, so Resident #8 gave the razor to Resident #3 to borrow on 7/23/24; -Before the 6:00 A.M. smoke break, Resident #3 told Resident #8 he/she had cut his/her arm with the razor he/she borrowed, because he/she was upset about breaking up with Resident #13; -Resident #8 helped Resident #3 clean up his/her arm. Resident #8 used a paper towel to wipe the blood from Resident #3's arm; -Residents #8 and #3 went to smoke. Resident #1 was in the smoke room and heard them talking about Resident #3 cutting his/her arm; -Residents #8 and #3 went to Resident #3's room. Resident #8 got the razor from Resident #3. Resident #3 had taken the razor apart; -Hall Monitor G came to Resident #3's room and Resident #8 gave the razor to Hall Monitor G; -Hall monitor G put the razor in the sharps box. <p>During an interview on 7/29/24 at 1:40 P.M., Resident #3 said the following:</p> <ul style="list-style-type: none"> -He/She and Resident #13 got into an argument during the night; -He/She did not try to commit suicide, only hurt himself/herself; -He/She got the razor from Resident #8; -He/She told Resident #8 he/she wanted to shave without staff watching, not that he/she was going to hurt himself/herself; -He/She had been thinking about cutting for a few days; <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265330	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2024
NAME OF PROVIDER OR SUPPLIER North Village Park		STREET ADDRESS, CITY, STATE, ZIP CODE 2041 Silva Lane Moberly, MO 65270	
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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-He/She told Resident #8 after he/she cut his/her arm;</p> <p>-He/She cut his/her left forearm 18 times;</p> <p>-He/She went to smoke at 6:00 A.M. and told Resident #1 about cutting his/her arm;</p> <p>-Resident #1 reported the cutting to Hall Monitor G.</p> <p>During an interview on 7/25/24 at 12:54 P.M. Hall Monitor G said the following:</p> <p>-After the 11:00 P.M. smoke break on 7/23/24, Resident #3 sat in the commons area and watched television for awhile and then went to bed and stayed in his/her room;</p> <p>-After the 6:00 A.M. smoke break on 7/24/24, Resident #1 told Hall Monitor G Resident #3 got a razor and cut his/her arm;</p> <p>-Resident #1 said Resident #3 got the razor from Resident #8;</p> <p>-Hall Monitor G went to Resident #3's room and Resident #3 showed Hall Monitor G his/her arm where it had been cut several times;</p> <p>-Resident #3 said he/she got the razor from Resident #8;</p> <p>-Resident #8 was in the room and gave the razor to Hall Monitor G who then put the razor in a sharps container;</p> <p>-Hall Monitor G called the night shift supervisor and reported the incident;</p> <p>-Resident #8 could not remember which staff member gave him/her the razor.</p> <p>During an interview on 7/24/24 at 4:25 P.M., the night shift supervisor said the following:</p> <p>-Hall Monitor G called and reported Resident #3 had taken a razor apart and cut his/her arm;</p> <p>-Hall Monitor G said Resident #3 got the razor from Resident #8;</p> <p>-Resident #3 said he/she wasn't suicidal, he/she just liked the feeling of cutting;</p> <p>Review of a picture on 7/24/24 at 11:35 A.M. on the administrator's phone showed a picture of Resident #3's left forearm with approximately 15 to 20 superficial cuts in about a four inch span from his/her wrist towards his/her elbow.</p> <p>Review of Resident #3's hospital records, dated 7/25/24, showed the following:</p> <p>-The resident self-harmed by superficial cutting on his/her arm in attempt to feel better;</p> <p>-The resident had suicidal ideations without intent or plan;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265330	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2024
NAME OF PROVIDER OR SUPPLIER North Village Park		STREET ADDRESS, CITY, STATE, ZIP CODE 2041 Silva Lane Moberly, MO 65270	
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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-The resident had depression symptoms for the last few months;</p> <p>-The resident had emotional reactivity (to experience frequent and intense emotional arousal - to be in a state of fight or flight) and dysregulation (a mental health symptom that involves trouble controlling your emotions and how you act on those feelings) after a breakup with Resident #13;</p> <p>-The resident continued to endorse suicidal ideations with a plan to cut his/her wrists and bleed to death;</p> <p>-The resident reported experiencing worsening depression symptoms for the last few months, including decreased appetite, feeling low, and hopeless;</p> <p>-The resident said he/she had nightmares of past trauma that felt like flashbacks. The nightmares had increased due to stressors with Resident #13.</p> <p>During an interview on 7/24/24 at 11:35 A.M., 2:45 P.M. the administrator said the following:</p> <p>-Resident #8 should not have had the razor in her possession after shaving; staff should have taken the razor;</p> <p>-Residents should be supervised at all times with a razor and after each use the razor should go to the sharps container;</p> <p>-Staff are educated about resident use of razors during orientation;</p> <p>-Staff should monitor residents when they give them a razor to shave and ensure the razor was returned to staff when residents are finished shaving;</p> <p>-The facility did not have a system in place to keep track of razors or count razors.</p> <p>NOTE: At the time of the survey, the violation was determined to be at the immediate jeopardy level J. Based on interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to remove the IJ violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements.</p> <p>At the time of exit, the severity of the deficiency was lowered to the D level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action to be taken to address Class I violation(s).</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265330	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2024
NAME OF PROVIDER OR SUPPLIER North Village Park		STREET ADDRESS, CITY, STATE, ZIP CODE 2041 Silva Lane Moberly, MO 65270	
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)		
<p>F 0742</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>42594</p> <p>Based on observation, interview and record review, the facility failed to ensure one resident (Resident #4) of 13 sampled residents, with mental disorders who lived on a secured locked unit, received individualized treatment and services to meet the resident's needs. The facility failed to ensure the resident received timely and appropriate treatment or services, including administering medications that were prescribed by the physician. The facility census was 178.</p> <p>Review of the facility policy Behavioral Health Services, dated 6/26/24, showed the following:</p> <ul style="list-style-type: none"> -It is the policy of the facility to ensure all residents receive necessary behavioral health services to assist them in reaching and maintaining their highest level of mental and psychosocial functioning; -Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders, psychosocial adjustment difficulty, and trauma or post-traumatic stress disorders; -Staff will monitor the resident closely for expressions or indication of distress, assess and develop a person-centered care plan for concerns identified in the resident's assessment; -The care plan shall have interventions that are person-centered, evidence based, culturally competent, trauma informed, and in accordance with professional standards of practice, reflect the resident's goals, use pharmacological interventions only when non-pharmacological interventions are ineffective or when clinically indicated. <p>1. Review of Resident #4's care plan, dated 9/23/23, showed the following:</p> <ul style="list-style-type: none"> -The resident was perseverated (to intently focus one's attention on a thought) on medications; -The resident had a behavior problem of becoming verbally and physically aggressive and had a history of suicide attempts related to bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs) and schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves); -Administer medications as ordered. Monitor/document for side effects and effectiveness; -Anticipate and meet the resident's needs; -The resident's coping skills included smoking and listening to music. <p>Review of the resident's annual Minimum Data Set (MDS, a federally mandated assessment instrument required to be completed by facility staff), dated 6/23/24, showed the following:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265330	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2024
NAME OF PROVIDER OR SUPPLIER North Village Park		STREET ADDRESS, CITY, STATE, ZIP CODE 2041 Silva Lane Moberly, MO 65270	
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)		
<p>F 0742</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-The resident was cognitively intact;</p> <p>-The resident had diagnoses that included medically complex conditions, paranoid (paranoia is a pattern of behavior where a person feels distrustful and suspicious of other people and acts accordingly) schizophrenia, bipolar disorder, and traumatic brain injury (TBI - a brain injury that was caused by an outside force that can cause problems with how a person thinks, understands, moves, communicates and acts).</p> <p>Review of the resident's progress notes, dated 6/8/24, showed the following:</p> <p>-At 8:04 A.M., Wellbutrin XL (used to treat depression) oral tablet extended release 300 mg was not available and the facility was waiting on a preauthorization from insurance;</p> <p>-At 10:03 A.M., staff called a code green (behavioral emergency) because the resident was agitated because his/her morning dose of Wellbutrin was not available. Staff educated to obtain the Wellbutrin from the Omnicell (automated emergency medication system) so the resident would not miss a dose. The pharmacy reported the resident's insurance would not pay for Wellbutrin because they needed a prior authorization form. The Director of Nursing (DON) was notified of the same concerns and reports on 6/7/24.</p> <p>Review of the resident's progress notes, dated 6/8/24 at 10:45 A.M. showed the resident was tearful and apologetic for becoming aggressive over his/her medications.</p> <p>Review of the resident's Medication Administration Record (MAR), dated 6/8/24, showed no documentation staff administered Wellbutrin XL oral tablet extended release 300 mg to the resident.</p> <p>Review of the resident's psychiatrist's notes, dated 6/10/24, showed the following:</p> <p>-The resident was seen for evaluation of sleep, mood, anxiety, delusions and medication;</p> <p>-The resident endorsed auditory hallucination (sensory perceptions of hearing in the absence of an external stimulus) without details;</p> <p>-No recent behaviors or concerns were reported;</p> <p>-Diagnosis of paranoid schizophrenia; review of safety precautions with cognitive decline. Review of medications showed Abilify extended release (a medication used to treat certain mental/mood disorders), maintenance injection 400 mg once every 28 days.</p> <p>Review of the resident's psychiatrist's notes, dated 6/17/24, showed a nurse practitioner's (NP) visit encounter that showed the following:</p> <p>-The resident was seen for a medication follow up;</p> <p>-Medication list was updated on 6/14/24 that included Abilify extended release maintenance injection 400 mg once every 28 days and Wellbutrin XL extended release 24 hour, 300 mg;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265330	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2024
NAME OF PROVIDER OR SUPPLIER North Village Park		STREET ADDRESS, CITY, STATE, ZIP CODE 2041 Silva Lane Moberly, MO 65270	

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)
<p>F 0742</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-The resident was seen for medication reconciliation for re-evaluation of paranoid schizophrenia, depression, and anxiety;</p> <p>-The resident resided in a long term care facility locked unit due to the need for ongoing nursing care and medication monitoring;</p> <p>-No acute changes reported;</p> <p>-Paranoid schizophrenia was stable and continue Abilify maintenance extended release 400 mg maintenance injection, 400 mg once every 28 days;</p> <p>-Severe episodes of recurrent major depressive disorder without psychotic features, no acute signs or symptoms, continue Wellbutrin XL 300 mg daily.</p> <p>Review of the resident's progress notes, dated 6/18/24, showed a plan of care note by the resident's primary care physician that showed the following:</p> <p>-The resident was seen for evaluation of sleep, mood, anxiety, delusions and medication reconciliation;</p> <p>-The resident endorsed auditory hallucination without details;</p> <p>-Paranoid schizophrenia in exacerbation (an acute increase in the severity of a problem, illness, or bad situation);</p> <p>-Review of safety precautions with cognitive decline;</p> <p>-Review of medications: Abilify extended release maintenance injection 400 mg once every 28 days.</p> <p>Review of the resident's MAR, showed Abilify extended release 400 mg intramuscularly (IM) one time a day every 28 days related to schizophrenia scheduled to be administered on 06/19/24. Staff left the date blank which indicated staff did not administer the medication.</p> <p>Review of the resident's progress notes, dated 6/27/24, showed an order administration note: Wellbutrin XL extended release 24 hour, 300 mg by mouth one time day for depression, medication not available, too soon to reorder.</p> <p>Review of the resident's MAR, dated 6/27/24, showed staff did not administer Wellbutrin XL.</p> <p>Review of the resident's progress notes, dated 6/30/24, showed a behavior note the resident pulled the fire alarm. The resident said he/she pulled the alarm because he/she was upset about medication concerns.</p> <p>Review of the resident's MAR, dated June 2024, showed the following:</p> <p>-The resident missed two doses of Wellbutrin XL on 6/8/24 and 6/27/24;</p> <p>-The resident missed his/her monthly injection of Abilify on 6/19/24.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265330	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2024
NAME OF PROVIDER OR SUPPLIER North Village Park		STREET ADDRESS, CITY, STATE, ZIP CODE 2041 Silva Lane Moberly, MO 65270	
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)		
<p>F 0742</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's progress notes, dated 7/6/24, showed the following:</p> <ul style="list-style-type: none"> -At 4:15 P.M., a behavior note showed the resident was observed to be verbally aggressive towards the certified medication technician (CMT). Immediate staff intervention and separation from peers. The resident was not easily redirected and continued to be verbally aggressive to staff and peers; -Staff contacted long term psychological management and got a new order for olanzapine (used to treat schizophrenia) 10 mg injection, one time only. Staff administered the injection and the resident calmed down. Staff will continue to monitor for protective oversight; -At 4:51 P.M., the resident rested in bed and said he/she was sorry for his/her behavior. <p>Review of the resident's progress notes, dated 7/7/24, showed the following:</p> <ul style="list-style-type: none"> -At 1:06 P.M., the resident told the nurse he/she felt anxious and requested an as needed (PRN) medication; -At 1:11 P.M., staff gave the resident PRN olanzapine 10 mg by mouth. <p>Review of the resident's MAR, dated 7/7/24, showed a new order for olanzapine 10 mg by mouth every eight hours as needed for agitation/anxiety for 14 days.</p> <p>Review of the resident's progress notes dated, 7/9/24, showed the following:</p> <ul style="list-style-type: none"> -The resident said he/she was extremely anxious and wanted a PRN medication; -Staff walked the resident through coping skills and once done the resident said the coping skills were ineffective. The resident was pacing aimlessly and talking fast; -The staff administered a PRN olanzapine 10 mg by mouth. <p>Review of the resident's progress notes dated, 7/10/24, showed the following:</p> <ul style="list-style-type: none"> -At 8:21 A.M., the resident said he/she was extremely anxious and wanted an as needed medication; -The resident said he/she had some anxiety; -The resident said he/she had been having dreams where he/she felt stuck; -Staff talked the resident through his/her coping skills and then would check in with the resident in an hour; -At 10:27 A.M., the resident said his/her coping skills were ineffective and he/she wanted a PRN medication because he/she was still anxious and did not want to blowup later. The resident wanted to have a good day; -Staff administered a PRN olanzapine 10 mg by mouth. <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265330	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2024
NAME OF PROVIDER OR SUPPLIER North Village Park		STREET ADDRESS, CITY, STATE, ZIP CODE 2041 Silva Lane Moberly, MO 65270	

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)
<p>F 0742</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's progress notes dated, 7/11/24, showed the following:</p> <ul style="list-style-type: none"> -At 4:01 A.M., the resident requested a PRN medication because he/she had anxiety; -At 4:03 A.M., staff administered PRN olanzapine 10 mg by mouth and encouraged the resident to use coping skills. <p>Review of the resident's progress notes dated, 7/17/24, showed the resident's Wellbutrin XL 300 mg was not available.</p> <p>Review of the resident's MAR, dated 7/17/24, showed the following:</p> <ul style="list-style-type: none"> -Staff did not administer the resident's Wellbutrin XL 300 mg; -Abilify extended release 400 mg intramuscularly one time a day every 28 days related to schizophrenia was scheduled to be administered. The date was left blank which indicated staff did not administer the medication. <p>During an interview on 7/30/24 at 4:18 P.M., Licensed Practical Nurse (LPN) H said the following:</p> <ul style="list-style-type: none"> -Resident #4's Abilify probably wasn't available; -LPN H did call the pharmacy and they said it would be delivered the next day and that is why he/she did not chart anything, so that the next nurse would know to administer the medication. Or the pharmacy said it wasn't covered by insurance; -LPN H was not for sure what the pharmacy said; -LPN H would have reported the missed medication to the nurse that came on the next shift and he/she would have reported it in the nurse's meeting; -Resident #4 was loud and agitated and pulled the fire alarm; -If Resident #4 asked for a PRN medication it was usually because he/she was anxious. <p>Review of the resident's progress notes dated, 7/18/24, showed the resident's Wellbutrin XL 300 mg was not available.</p> <p>Review of the resident's MAR, dated 7/18/24, showed staff did not administer the resident's Wellbutrin XL 300 mg.</p> <p>Review of the resident's progress notes dated, 7/19/24, showed the following:</p> <ul style="list-style-type: none"> -At 8:26 A.M., the resident's Wellbutrin XL 300 mg was not available and staff would follow up with the pharmacy; -At 8:50 A.M., noted that the resident missed a dose of his/her Wellbutrin XL 300 mg. The resident's physician was notified. Wellbutrin was in the building and would be administered per schedule; <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265330	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2024
NAME OF PROVIDER OR SUPPLIER North Village Park		STREET ADDRESS, CITY, STATE, ZIP CODE 2041 Silva Lane Moberly, MO 65270	

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)
<p>F 0742</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-At 8:56 A.M., long term psych management notified the resident missed his/her Wellbutrin XL 300 mg;</p> <p>-At 6:00 P.M., staff removed the Wellbutrin from the Omnicell for the morning dose.</p> <p>Review of the resident's MAR, dated 7/19/24, showed staff did not administer the resident's Wellbutrin XL 300 mg at any time that day.</p> <p>Review of the resident's progress notes dated, 7/25/24, showed the following:</p> <p>-Housekeeping attempted to deep clean the resident's room when the resident began screaming at and threatening the housekeeper;</p> <p>-A code green was called.</p> <p>Review of the resident's progress notes, dated 7/27/24, showed the following:</p> <p>-At 3:40 A.M., the resident reported to the staff he/she did not receive his/her monthly injection;</p> <p>-Staff told the resident they would have to look it up and let the resident know why he/she did not get his/her injection;</p> <p>-Five minutes later the fire alarm went off;</p> <p>-Staff said Resident #4 pulled the fire alarm because staff took too long to give him/her the injection;</p> <p>-The resident yelled and it upset the other residents. Staff separated all the residents but Resident #4 continued to yell;</p> <p>-Resident #4 could not utilize his/her coping skills and could not be redirected;</p> <p>-Staff obtained an order for Thorazine (used to treat schizophrenia and bipolar disorder) 50 mg injection;</p> <p>-At 4:50 A.M., staff administered PRN Thorazine 50 injection to the resident;</p> <p>-At 12:00 P.M., the resident pulled the fire alarm two times, he/she was delusional and said everyone was trying to kill him/her. Staff obtained an order to send the resident to the hospital for evaluation.</p> <p>Review of the resident's care plan, dated 7/28/24, showed the following:</p> <p>-Problem: this is my safety plan;</p> <p>-My personal goal is: make healthy decisions;</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265330	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2024
NAME OF PROVIDER OR SUPPLIER North Village Park		STREET ADDRESS, CITY, STATE, ZIP CODE 2041 Silva Lane Moberly, MO 65270	
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)		
<p>F 0742</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-Interventions: the resident had one PRN (as needed) medication if he/she needed it, his/her warning sign was anxiousness, review the resident's medication with him/her to ensure he/she understood what medications the resident took and why, the following are ways the resident could be distracted or methods that comfort him/her including smoking, TV, games, group, and phone calls, the following worked well for the resident during his/her past crisis moments: sleeping and talking.</p> <p>Review of the resident's physician order sheet (POS), dated 7/29/24, showed the following:</p> <p>-Abilify extended release 400 mg injection once every 28 days start on 4/24/24;</p> <p>-Thorazine 50 mg injection every 12 hours as needed for agitation/anxiety related to paranoid schizophrenia and bipolar disorder start on 7/27/24;</p> <p>-Wellbutrin XL extended release 300 mg by mouth one time a day for depression start on 5/27/24.</p> <p>Review of the resident's MAR, dated July 2024, showed the following:</p> <p>-The resident missed three consecutive doses of Wellbutrin XL on 7/17/24, 7/18/24, and 7/19/24;</p> <p>-The resident missed his/her monthly injection of Abilify on 7/17/24.</p> <p>During an interview on 7/9/24 at 3:08 P.M., Licensed Practical Nurse (LPN) A/Resident Care Coordinator said the following:</p> <p>-The pharmacy said Resident #4's Abilify was not covered by insurance;</p> <p>-If a medication is not available on the medication cart for a resident, staff should call the pharmacy to check on it, call the physician, and notify the DON.</p> <p>During an interview on 7/29/24 at 5:19 P.M. the Assistant Director of Nursing (ADON) said the following:</p> <p>-If a medication was not available she would expect the staff to chart that on the MAR;</p> <p>-She would expect staff to call the pharmacy and find out why the medication wasn't at the facility;</p> <p>-She would expect the nurse to call the physician and get an alternative medication if the one prescribed was not covered by insurance.</p> <p>During an interview on 7/29/24 at 5:19 P.M. the Assistant Director of Nursing (ADON) said the following:</p> <p>-If a medication was not available she would expect the staff to chart that on the MAR;</p> <p>-She would expect staff to call the pharmacy and find out why the medication wasn't at the facility;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265330	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2024
NAME OF PROVIDER OR SUPPLIER North Village Park		STREET ADDRESS, CITY, STATE, ZIP CODE 2041 Silva Lane Moberly, MO 65270	
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)		
<p>F 0742</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-She would expect the nurse to call the physician and get an alternative medication if the one prescribed was not covered by insurance.</p> <p>Review of the resident's psychiatric hospital discharge records, dated 8/3/24, showed the following:</p> <p>-Arrival to hospital 7/27/24;</p> <p>-Chief complaint: the resident came from a skilled nursing facility for a mental health evaluation. The resident made suicidal statements and had exhibited increasing paranoia;</p> <p>-Admission Impression: the resident was not safe for discharge and was admitted to inpatient with suicidal ideations due to voices that told him/her to kill himself/herself;</p> <p>-Duration of symptoms prior to arrival: days prior to admission;</p> <p>-On 8/3/24 the resident was ready and agreeable to discharge to the skilled nursing facility.</p> <p>During an interview on 8/6/24 at 9:38 A.M., and 8/8/24 at 9:20 A.M. the DON said the following:</p> <p>-There were no medications pulled from the Omnicell for Resident #4 during the months of June and July 2024;</p> <p>-She did not recall LPN H ever reporting in a nursing meeting that the resident's Abilify or Wellbutrin were not available for administration;</p> <p>-She expected nurses to call the pharmacy and the physician when a medication was not available to a resident;</p> <p>-If she was notified a medication was not available, she called the physician to notify them and to get a new order, either to put the medication on hold or get an alternative;</p> <p>-She was made aware that the resident missed his/her Abilify monthly injections for June and July 2024 on the day the resident was sent to the hospital (7/27/24);</p> <p>-She did not know why the resident pulled the fire alarm, the resident just did that when he/she was cycling.</p> <p>During an interview on 8/8/24 at 8:33 A.M., the resident said the following:</p> <p>-He/She pulled the fire alarm at the facility to get attention because he/she didn't get medications;</p> <p>-The resident felt he/she was neglected;</p> <p>-He/She doesn't get to see the psychiatrist, he/she had not seen the psychiatrics in two months.</p> <p>During an interview on 8/8/24 at 9:11 A.M., the Administrator said the following:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265330	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2024
NAME OF PROVIDER OR SUPPLIER North Village Park		STREET ADDRESS, CITY, STATE, ZIP CODE 2041 Silva Lane Moberly, MO 65270	
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)		
<p>F 0742</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-He expected staff to contact the resident's physician when his/her medications were not available;</p> <p>-He expected staff to contact the psychiatric physician for an appointment when the resident was having behaviors;</p> <p>-The resident was on a schedule with the psychiatric physician/NP for regular visits. He did not know for sure how often the resident was seen;</p> <p>-If the resident did not get his/her regimen of prescribed medications it could increase his/her behaviors and actions.</p> <p>MO239610</p>		