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	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Village Park	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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35615 Based on interview and record review, the facility failed to ensure one resident (Resident #1) in a review of 18 sampled residents, was treated with dignity and respect when Licensed Practical Nurse (LPN) A tried to prevent the resident from taking a cup from the dining room back to his/her room. The resident attempted to take the cup from LPN A and the drink mix ended up on both the resident and LPN A. The facility census was 181. Review of the facility policy Dignity and Respect, dated 6/29/23, showed the following: -Every resident had a right to be treated with dignity and respect; -All staff would speak to and treat all residents with dignity and respect. 1. Review of Resident #1's Care Plan, updated 7/28/24, showed the following: -Diagnoses of depression, weakness and abnormal gait and mobility; -The resident had behaviors of agitation and anxiety, triggers of being yelled at and arguing. Staff should avoid triggering the resident. The resident's coping skills were visiting peers, watching television, wandering halls and sleeping to prevent behaviors; -Impaired communication due to difficulty hearing. Staff should allow adequate time for the resident's response, and encourage communication; -Depression related to admission in a facility and being away from family. Staff should monitor the resident for self-harm, refusing to eat or drink, refusing medications or therapies, impaired judgment or safety awareness. Monitor for hopelessness, anxiety, and sadness. Review of the resident's annual Minimum Data Set (MDS) a federally mandated assessment instrument, completed by facility staff, dated 6/14/24, showed the resident had moderately impaired cognition. Review of the resident's quarterly MDS, dated [DATE], showed the resident was independent in Activities of Daily Living and self-propelled a wheelchair for mobility. (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

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 10/03/2024
NAME OF PROVIDER OR SUPPLIER: North Village Park		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility Registered Nurse Investigation (RNI), dated 9/26/24, showed on 9/24/24 Resident #1 was leaving the dining room with a cup of red drink mix to take to his/her room. LPN A stopped the resident because he/she was not able to take the cup from the dining room and offered a disposable cup. The resident attempted to take the cup from LPN A, the cup of drink mix spilled on LPN A and Resident #1. During an interview on 10/1/24 at 9:30 A.M., LPN B said on 9/24/24 around 5:30 P.M., he/she saw Resident #1 leave the dining room area with a cup of red colored drink mix. LPN A told the resident he/she could not take the dietary department drink cup to his/her room. The resident tried to dump the cup full of red colored drink mix toward LPN A. LPN A snatched the cup and the red colored drink mix ended up on the resident's face. LPN A walked away. The resident was upset following the incident. LPN A let other residents leave the dining room with a disposable cup of red colored drink mix. LPN A was disrespectful to the resident. During an interview on 10/1/24 at 10:00 A.M. LPN C said he/she interviewed Resident #1 following the incident. The resident was upset and said he/she was mad that LPN A took his/her drink and did not let the resident take the drink back to his/her room. Residents were allowed to take drinks from the dining room in a disposable cup but not in the dietary department cup. During an interview on 10/1/24 at 10:25 A.M. Resident #1 said LPN A poured red drink mix on his/her head. LPN was rude and took his/her cup away. During an interview on 10/1/24 at 11:00 A.M. Resident #17 said he/she saw Resident #1 carry a box of seasonings and personal things to the dining room for meals. Resident #1 held the box following supper and left the dining room in a wheelchair. LPN A grabbed the resident's cup of red colored drink mix out of the box and said he/she could not have that cup in his/her room. Resident #1 tried reaching for the cup and LPN A threw the cup of red colored drink mix towards Resident #1. The drink sloshed all over the resident's face and on LPN A. LPN A was not nice, the resident had red colored drink mix all over his/her face and clothes. During an interview on 10/1/24 at 11:15 A.M. Resident #16 said he/she saw Resident #1 carry a box of condiments out of the dining room and had a cup of red colored drink mix in the box. LPN A took the drink cup and the cup of red colored drink mix ended up on Resident #1's face. Resident #1 went down the hall in the wheelchair afterward. Resident #16 felt bad for Resident #1. LPN A was rude. During an interview on 10/1/24 at 11:20 A.M. Resident #15 said he/she saw Resident #1 carry a box of personal things out of the dining room. LPN A grabbed Resident #1's drink cup from the box. The red drink mix dumped on Resident #1's face. Resident #15 did not know why LPN A took the drink cup from Resident #1's box. LPN A should not have poured the drink on the resident. Resident #1 went down the hall following the incident with red colored drink mix on his/her face and hair. LPN A returned to the dining room with Resident #1's cup and slammed the cup on the counter before washing the red drink mix off his/her hands and arms. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/1/24 at 12:15 P.M. Certified Nurse Assistant (CNA) D said on 9/24/24 at supper time, he/she saw LPN A tell Resident #1 he/she could not take a dietary cup from the dining room and offered to pour the cup of red drink mix into a disposable cup. The resident acted like he/she would throw the red drink mix, LPN A took the cup from the resident and the cup of red drink mix ended up on the resident's face. CNA D did not hear LPN A say anything to the resident after pouring the drink in the resident's face. CNA D had not seen LPN A do anything like that before. During an interview on 10/1/24 at 11:35 A.M. LPN A said on 9/24/24 after supper Resident #1 left the dining room with a dietary cup. LPN A took the cup of red drink mix out of the resident's box of personal items the resident carried to meals. LPN A planned to pour the drink in a disposable cup for the resident. Residents were not allowed to take the dietary cups out of the dining room. As he/she took the cup, the resident was upset and threw the cup at LPN A. LPN A grabbed the cup and the red drink mix splashed up in the resident's face. LPN A told Resident #1 he/she was sorry at the time the incident occurred. LPN A should have asked the resident for the cup of red drink mix instead of taking the cup. LPN A did not mean to spill the drink on the resident. The resident often lost his/her tempter and LPN A usually talked with the resident to calm him/her down. LPN A spoke with the resident later in the resident's room. At that time the resident was not upset or mad. During an interview on 10/3/24 at 3:00 P.M. the Director of Nursing said LPN A was disrespectful and should not have taken the drink from the resident. LPN A should have provided the resident a disposable drink cup when he/she left the dining room. During an interview on 10/3/24 at 3:15 P.M. the Administrator said he/she expected staff to treat residents with respect. Staff should provide residents with disposable cups to take from the dining room. MO 00242723 MO 00242713

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 35615 Based on interview and record review, the facility failed to ensure one resident (Resident #10), in a review of 18 sampled residents, received care and treatment in accordance with professional standards of practice. Staff failed to assess and obtain treatment for seven days following the resident's complaints of urinary urgency (a sudden and strong need to urinate) and dysuria (difficulty urinating) and failed to obtain a urinalysis (a diagnostic laboratory procedure used to determine urinary changes and infection) as ordered by the physician. The resident was admitted to the hospital with acute pyelonephritis (a bacterial infection of the kidneys that caused inflammation. A severe urinary tract infection), and complicated urinary tract infection. Upon readmission staff failed to obtain and administer four doses of the physician ordered antibiotic for the resident. The facility census was 181. Review of the facility policy Notification of Changes, dated 5/14/24, showed the following: -The purpose was to ensure the facility promptly informed the resident and consulted the resident's physician when there was a change requiring notification; -Circumstances requiring notification were accidents, significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status that may included life-threatening conditions or clinical complications. Review of the facility policy Transcription of Orders/Following Physician Orders, dated 5/18/24, showed the following: -The purpose was to outline procedures in accurately transcribing physicians' orders and to ensure all physicians' orders were followed. To ensure a process was in place to monitor nurses in accurately transcribing and following physicians' orders; -Upon receiving a physician's order, it would be documented in the resident's electronic medical record in the order section; -The licensed nurse would check the emergency kit to verify if the medication was present in the facility to begin immediately. If the medication was not available, the facility may contact the backup pharmacy to deliver the medication sooner. If the medication was unable to be started within 24 hours of the order, the prescribing physician would be notified, and further orders would be obtained. If a stat (without delay) medication was ordered, the physician would be made aware of facility availability in the case an alternative was needed; -After laboratory testing, diagnostic testing or other services were ordered, the nurse would document orders in the resident's electronic medical record and fill out the corresponding requisition for the specific services to be obtained; (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-The licensed nurse would review electronic Medication Administration Records (MARs) on a routine basis to monitor for medications that were not administered to the resident due to unavailability, refusal, omission, etc. If a medication was marked as not given, the reasoning for not being given should be explained in the progress notes and Director of Nursing or supervising nurse and the Administrator must be notified. The physician must also be notified. The nurses' progress notes must document the plan/solution because of the medication not being administered and any adverse reactions that the resident may have. For electronic MARs the medication would be documented as not given by selecting the corresponding chart code for the reason why it was not given, and a progress note would be written; -If the medication was unavailable, the licensed nurse would contact the pharmacy and have the medication delivered. If the resident was not going to receive their scheduled medication per the physician's orders, the licensed nurse would contact the Director of Nursing (DON), the Administrator, and the physician. The nurse would then follow any further orders provided by the physician. 1. Review of Resident #10's annual Minimum Data Set (MDS) a federally mandated assessment instrument completed by facility staff, dated 6/21/24, showed the following: -Cognitively intact; -Independent in activities of daily living; -Continent of bowel and bladder. Review of the resident's Care Plan, updated 6/24/24, showed the following: -Diagnoses of depression, shortness of breath, and urinary incontinence; -The resident was highly functional and able to complete activities of daily living with supervision. Staff should provide assistance as needed. Review of the resident's Care Plan showed the resident's urinary incontinence diagnosis was not addressed. Review of the resident's Physician Order Sheet (POS), dated 9/15/24, showed to obtain urinalysis with culture and sensitivity (diagnostic lab procedure used to identify the type of bacteria causing an infection). Review of the resident's nurses note, dated 9/17/24 at 1:32 P.M., showed staff documented the resident currently complained of urgency and dysuria. A urinalysis with culture and sensitivity was ordered and urine sample sent to the laboratory on 9/16/24. The results were currently not available. Review of the resident's nurses' notes showed staff documented the following: -On 9/18/24 at 1:00 P.M. the resident was continent of bowel and bladder; -On 9/19/24 at 1:45 P.M. the resident was continent of bowel and bladder, able to make needs and concerns known; (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-On 9/21/24 at 9:37 A.M. the resident believed an antibiotic was ordered on 9/19/24 for a possible urinary tract infection. No physician orders noted for an antibiotic, attempted to reach the physician at number provided with no answer and no voice mail set up; -On 9/21/24 at 11:28 A.M. attempted to reach the physician again with no answer and unable to leave a message. Review of the resident's POS, dated 9/21/24, showed an order from the resident's physician for Bactrim DS (antibiotic medication) 800/160 milligrams (mg) one tablet two times daily for urinary tract infection for seven days. Review of the resident's Medication Administration Record (MAR) dated September 2024 showed the following: -On 9/21/24 no documentation staff administered Bactrim DS 800/160 mg as ordered two times daily; -On 9/22/24 no documentation staff administered Bactrim DS 800/160 mg as ordered two times daily; -On 9/23/24 staff documented Bactrim DS 800/160 mg administered at 7:00 A.M. and 4:00 P.M. Review of the resident's nurses' notes showed staff documented the following: -On 9/23/24 at 8:55 P.M., the resident wanted to be sent out to the hospital, he/she did not feel right, was short of breath and his/her abdomen hurt due to a urinary tract infection. Temperature of 101.8 degrees (normal 98.6 degrees), blood pressure 141/111 (normal 120/80), heart rate 92 beats per minute (normal 60 to 80), respirations 18 breaths per minute (normal 12-18). Resident was sent by ambulance to the local hospital; -On 9/24/24 at 2:04 P.M., the resident was transferred from the local hospital to a regional hospital and admitted with fluid overload and urinary tract infection. Review of the resident's hospital discharge summary, dated 9/28/24, showed the following: -Diagnoses of acute pyelonephritis (a bacterial infection of the kidneys that caused inflammation. A severe urinary tract infection), complicated urinary tract infection, hematuria (blood in the urine) likely secondary to infection, electrolyte derangements (imbalance of the electrolyte levels in the blood); -Intravenous (IV) ceftriaxon (antibiotic medication) treatment from 9/24/24 to 9/28/24; -Transition to cefpodoxime (oral antibiotic medication) on 9/28/24 to complete a 14-day course of treatment, end date of 10/7/24; -New medications cefpodoxime 200 mg, one tablet every 12 hours for ten days. Review of the resident's nurses note, dated 9/28/24 at 3:42 P.M., showed staff documented the resident returned from the hospital. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's clinical admission note, dated 9/28/24 at 4:33 P.M., showed staff documented the resident arrived back at the facility. Denies urinary complaints, urine clear yellow. Currently on antibiotics. Review of the resident's POS, dated 9/28/24, showed cefpodoxime 200 mg one tablet every 12 hours for pyelonephritis for ten days. Review of the resident's MAR, dated September 2024, showed the following: -On 9/28/24 no documentation staff administered cefpodoxime 200 mg at 9:00 P.M.; -On 9/29/24 at 9:00 A.M. staff documented cefpodoxime 200 mg was not administered, see progress (nurses note) notes. Review of the resident's nurses notes dated 9/29/24 at 10:13 A.M., showed staff documented cefpodoxime 200 mg not administered, the medication had not arrived from the pharmacy. Review of the resident's MAR dated September 2024 showed on 9/29/24 at 9:00 P.M. staff documented cefpodoxime 200 mg not administered, see progress notes. Review of the resident's nurses note, dated 9/29/24 at 9:38 P.M., showed staff documented cefpodoxime 200 mg not administered, the medication had not arrived from the pharmacy. Review of the resident's MAR dated September 2024 showed on 9/30/24 at 9:00 A.M., staff documented cefpodoxime 200 mg not administered, see progress notes. Review of the resident's nurses note, dated 9/30/24 at 10:30 A.M., showed staff documented cefpodoxime 200 mg not administered, the medication had not arrived from the pharmacy. Pharmacy notified of missing medication. Review of the resident's medical record showed no documentation staff notified the resident's physician cefpodoxime 200 mg was not administered on 9/28/24 at 9:00 P.M., on 9/29/24 at 9:00 A.M. and 9:00 P.M. or 9/30/34 at 9:00 A.M. Review of the resident's nurses note, dated 9/30/24 at 7:20 P.M., showed the physician made rounds, discussed the antibiotic orders. Antibiotic changed to Cipro (oral antibiotic) for pyelonephritis. Review of the resident's POS, dated 9/30/24, showed the following: -Discontinue cefpodoxime 200 mg twice daily; -Cipro 500 mg two times daily for acute pyelonephritis for seven days. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 10/3/24 at 9:50 A.M., the resident said he/she had urinary symptoms about three weeks ago of burning and hematuria. He/She told staff and a urine sample was obtained. Two days later staff said the urine sample was sent to the wrong laboratory and he/she had to start over. Staff said an antibiotic was ordered but did not come from the pharmacy. After a few days the resident asked staff to call the physician for another antibiotic order which he/she did not receive. His/Her urinary symptoms continued to get worse. The resident did receive one dose of an antibiotic, was not improving, and asked to go to the hospital for treatment. The resident felt short of breath, his/her kidneys were not working very well, and his/her abdomen was hard. The resident felt like fluid was backing up in his/her kidneys and abdomen. Staff sent the resident to the hospital by ambulance. He/She did not receive the new antibiotic ordered on discharge from the hospital. The pharmacy did not send the antibiotic because his/her insurance did not cover the cost. The resident's physician changed the antibiotic that was started a few days after his/her hospital discharge. Staff did not assess the resident and try to get him/her treatment for the urinary symptoms and did not arrange for hospital transfer until the resident asked to go to the hospital. During an interview on 10/3/24 at 3:00 P.M. the DON said staff should have assessed and documented the resident's condition and complaints of urinary urgency and dysuria. Staff should have called the physician and obtained treatment and not delayed treatment. If a urinalysis was obtained and treatment provided, hospitalization might have been prevented. The resident had history of urinary tract infections. He expected staff to assess a resident's condition and obtain treatment orders from the physician. Staff should document the assessments, findings, and communication with the physician. If the physician was not reached, staff should notify the administrative nursing staff for assistance. The resident should have received treatment much sooner. During an interview on 10/3/24 at 3:15 P.M. the Administrator said he expected staff to assess residents for change in condition, call the physician and obtain treatment as indicated. Staff should document assessments, communication with the physician, and follow up assessments. Staff should have obtained a urinalysis for the resident as ordered by the physician and followed up with treatment to prevent hospitalization . The resident was aware of his/her symptoms and told staff. Staff should not delay a resident's treatment. During an interview on 10/10/24 at 8:15 A.M. the facility Medical Director said he was on call for the previous month and had not received notification of the resident's urinary symptoms. He expected staff to notify him of any change in a resident's condition in order to obtain testing and implement treatment as soon as possible. Staff should not delay a resident's treatment. He was not aware the resident had urgency and dysuria and not aware staff had not completed the urinalysis. Staff should have called and notified him of the resident's condition, obtained the urinalysis, and started treatment to prevent hospitalization and worsening of the resident's condition. MO 00242406