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Form Approved OMB
No. 0938-0391

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 03/06/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46506 Based on interview and record review, the facility failed to ensure two residents (Resident #7 and #8) in a review of 14 sampled residents were free from physical abuse. Activity Aide A heard Resident #1 call Resident #7 a name and accused the resident of being sexually inappropriate with Resident #1's significant other. Activity Aide A did not report the comments to staff responsible for Resident #1 and Resident #7's care and supervision. Resident #1 went into Resident #7's room and hit him/her multiple times. The residents were separated. Resident #7 was sent to the hospital for evaluation and treatment. Resident #7 returned the facility with a diagnosis of general assault. Hall Monitor D saw Resident #6 leave his/her room and heard the resident say his/her hand hurt from hitting Resident #8. Hall Monitor D stayed in the hallway while Nurse Aide H questioned Resident #6 in the hallway outside of Resident #8's room. While being questioned by staff outside of the room, Resident #6 went back into the room and hit Resident #8 again. Resident #6 was sent to the hospital for an evaluation and treatment and returned to the facility. The facility census was 173. On 3/6/25 at 12:50 P.M., the administrator was notified of the past noncompliance which occurred on 2/26/25 and 2/28/25. On 2/26/25 the administrator became aware of the resident to resident abuse allegation involving Resident #1 and Resident #7. Upon discovery, the facility separated the residents, conducted an investigation, and notified appropriate parties. On 2/28/25 the administrator became aware of the resident to resident abuse allegation involving Resident #6 and Resident #8. Staff separated the residents, conducted an investigation, and notified appropriate parties. Staff reviewed the facility abuse policy, including resident to resident abuse, and all facility staff was educated on the facility abuse policy and expectations on monitoring and responding to residents. The deficiency was corrected on 3/3/25. Review of the facility's Abuse and Neglect policy, dated 6/12/24, showed the following: -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; (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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	265330	A. Building B. Wing	03/06/2025

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-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, and protection of residents and for the prevention of abuse; -The facility will identify, correct and intervene in situations in which abuse, neglect and/or misappropriation of resident property is more likely to occur; -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. 1. Review of Resident #1's Preadmission Screening and Resident Review (PASARR, federally mandated process ensuring individuals with serious mental illness, intellectual disability, or related conditions receive appropriate placement and services when considered for admission to a Medicaid-certified nursing facility), dated 2/19/21, showed historical symptoms were agitation, aggression, easily influenced by others, poor decision making skills and poor insight. Review of the resident's Care Plan, dated 11/11/24, showed the following: -The resident was a risk for altered mental status and mood swings related to a diagnosis of bipolar (a chronic mental health condition characterized by extreme mood swings, alternating between periods of elevated mood and low mood); -Behaviors: verbally aggressive, physically aggressive, pacing up and down, anxiety, false allegations and delusions; -If staff saw the resident exhibit any behaviors listed, refer to preferred coping skills immediately; -Calmly redirect the resident's inappropriate behavior. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by facility staff, dated 12/14/24, showed the following: -The resident had moderate cognitive impairment; -He/She walked independently at least 150 feet in a corridor or similar space. 2. Review of Resident #7's Care Plan, dated 11/14/24, showed the following: -He/She displayed an impaired thought process related to diagnoses of schizophrenia (serious brain disorder that causes people to interpret reality abnormally), hypersexual, and mild intellectual disability; -Provide intensive monitoring per unit/facility protocol to ensure protective oversights; (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She had episodes of being socially inappropriate at times; -He/She exhibited inappropriate behaviors while in the hangout (common area for socializing). Review of the resident's quarterly MDS, dated [DATE], showed the following: -The resident had moderately impaired cognition; -He/She walked independently at least 150 feet in a corridor or similar space. Review of the resident's facility acquired written statement, dated 2/26/25, showed the following: -The resident was in bed when Resident #1 entered the room without knocking; -Resident #1 randomly started hitting Resident #7 and just kept hitting; -Resident #1 brought up things Resident #7 did in the past; -Resident #1 then walked away. Review of the resident's Care Plan, updated 2/27/25, showed the following: -Resident to resident altercation on 2/26/25; -Skin assessment completed; -Pain assessment; -Post psychosocial assessment; -The staff sent the resident to the hospital; -The staff moved the resident to a different unit; -Legal guardian notified. Director of Nursing, Administrator, management, and primary care provider aware. 3. Review of the Administration/Registered Nurse Investigation, dated 2/27/25 at 12:16 A.M., showed the following: -Date of the incident was 2/26/25; -Type of incident was physical aggression involving head; -Resident #7 came out of his/her room with blood on his/her face; -Resident #7 said, Resident #1 was in his/her room and hit him/her multiple times in the face; (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The staff immediately put Resident #1 on one-on-one supervision; -Resident #7 had redness and swelling to the left side of the face, abrasion to upper left side of mouth, scratches to left side of neck, redness to back of neck and rated pain at 5 out of 10 with ten being the worst pain possible; -Staff sent Resident #7 to the hospital for evaluation and treatment; -Resident #1 had redness to his/her right hand between the second, third, and fourth knuckles; -Resident #4 (is this R #1 girlfriend/boyfriend?) said, he/she was joking with Resident #7 in the hangout when Resident #1 overheard this, he/she became upset, and began to have a verbal exchange with Resident #7; -The root cause was Resident #1 overhead Resident #7 in the hangout, joking with Resident #4 and was upset and had a verbal exchange, which led to Resident #1 attacking Resident #7. During an interview on 3/4/25 at 2:30 P.M., Resident #7 said the following: -Resident #1 entered the room and started hitting him/her; -He/She did not remember anyone else being there because he/she blacked out. During an interview on 3/5/25 at 10:30 A.M., Activity Aide A said the following: -Resident #1 came in the hangout; -Resident #1 said Resident #7 was a pervert and exhibited sexual behavior with Resident #1's friend in the past; -Resident #1 made the comment out loud and not directed to anyone in particular; -Activity Aide A did not report this interaction to anyone; -The next time he/she heard a resident call a peer anything, he/she will report it immediately; -If a resident said anything sexual to a resident or told them to stop talking or not say something, he/she should report it, it was part of abuse training. Review of Security Psych Aide I's facility acquired written statement, undated, showed Resident #7 was bleeding in the lip area and said Resident #1 beat him/her up. During an interview on 3/5/25 at 12:18 P.M., the Director of Nursing said the following: -She felt there was a physical altercation between Resident #1 and Resident #7 and Resident #1 went into Resident #7's room to fight about it. -Resident #7 was moved to a different unit. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/5/25 at 4:04 P.M., the Administrator said the following: -He knew there was a physical altercation between Resident #1 and Resident #7; -He felt Resident #1 entered Resident #7's room to do something because of Resident #7 said and past history with Resident #1's significant other; (R 4?) -Resident #1 had several altercations and behaviors in the facility; -The Interdisciplinary team met with the resident to discuss how the facility staff could help the resident with the behaviors to keep him/her and other resident's safe. 4. Review of Resident #6's PASARR, dated 12/13/23, showed the following: -Diagnoses: oppositional defiant disorder, ADHD, 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) major depressive disorder (common mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest or pleasure in activities), schizophrenia, generalized anxiety disorder (mental health condition characterized by excessive, persistent, and uncontrollable worry about various aspects of life), and psychosis (mental health condition characterized by a loss of touch with reality); -The resident had delusions, hallucinations, disorganized thinking and behaviors, agitation, inappropriate reactions, irritability, and low impulse control; -Supervision for safety of self and others; -It is recommended a safety plan be established at the skilled facility which addresses assault precautions should these become a treatment concern. Review of the resident's Care Plan, dated 12/7/24, showed the following: -The resident had a history of PTSD that affects his/her symptoms and may flare up without any known trigger; -The resident had manifestations of behaviors related to his/her mental illness that may create disturbances that affect others; -Behaviors: verbally aggressive and physically aggressive; -Coping Skills: watching television, walking halls, smoking, listening to music, one on one attention from staff; -The resident had the potential to be physically aggressive related to history of harm to others; -Analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document; (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. Review of the Administration/Registered Nurse Investigation, dated 2/28/25 at 11:16 P.M., showed the following: -Date of incident was 2/28/25; -Type of incident was physical aggression involving the head; -Person(s) involved in the incident was Resident #6 and Resident #8; -Witnesses were Hall Monitor D and NA H; -Resident #6 went into the shared room with Resident #8 to get something; -Resident #8 yelled at Resident #6 to shut the door; -Resident #6 struck Resident #8 in the head and walked out of the room; -Resident #8 yelled, he/she was going to press charges, then Resident #6 went back into the room and struck the resident again; -The staff heard the commotion, called a Code [NAME] (behavioral emergency), and immediately separated the residents; -The staff removed Resident #6 from the hall with one on one supervision from two staff members; -Neurological checks (medical evaluations designed to assess the functioning of the nervous system) started on Resident #8 and Resident #6 was sent to the hospital; -The facility staff did not respond appropriately due to Resident #6's ability to hit Resident #8 for a second time and the staff were discussing the situation out loud with prompted Resident #8 to get agitated again; -Staff education started. During an interview on 3/4/25 at 12:15 P.M., the Resident Care Coordinator (RCC) LPN E said the following: -He/She was the on-call person when Resident #6 and Resident #8 had their altercation and assisted the charge nurse over the phone; -At first, the staff were unaware a physical altercation occurred between the two residents; -After Resident #8 said he/she was pressing charges then Resident #6 went back in the room. During an interview on 3/4/25 at 12:24 P.M., Hall Monitor D said the following: -He/She was working on 300 Hall and NA H was working on 200 Hall; (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She heard a commotion over on 200 Hall, so he/she responded; -He/She saw Resident #6 as he/she left the room and was in the hallway; -Resident #6 said his/her hand hurt from hitting Resident #8, so he/she told the resident it was not appropriate to hit another resident; -NA H went to ask Resident #6 what happened and all of a sudden, Resident #6 went past both staff members and went back into the room; -Resident #6 was not on one on one supervision at that time, the staff were trying to figure out what happened. During an interview on 3/4/25 at 3:32 P.M., the Director of Nursing said the following: -She felt Resident #6 initially hit Resident #8 as a reaction to Resident #8; however, the second time staff were present and Resident #6 purposely went back into the room to hit Resident #8 again; -Her expectation was staff move residents out of a situation if there was a suspicion of an altercation; -The staff have to ask questions to determine if an altercation occurred prior to placing a resident on one on one supervision. During an interview on 3/6/25 at 12:50 P.M., the Administrator said the second time Resident #6 had to go past the staff with the purpose of hitting Resident #8 again because he/she didn't like what Resident #8 said. If a staff member heard or saw something that made them think an altercation happened or would happen, staff should intervene, separate the residents to try and de-escalate the situation. MO250233 MO250339