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	07/10/2025

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. (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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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one resident (Resident #2), in a review of 12 residents, was free from abuse when Resident #1, who was being monitored by staff one on one, entered Resident #2's room by the connecting bathroom and took a power strip cord, labeled with Resident #2's name. Resident #2 confronted Resident #1 about the missing power strip cord. Both residents' voices were raised and Hall Monitor A, the one on one staff, said he/she stood in front of Resident #2 to prevent him/her from entering Resident #1's room. Hall Monitor C entered the room to assist, pulled the power strip cord out from underneath Resident #1's leg and gave it back to Resident #2. Hall Monitor C left the room to locate a cord for Resident #1. Hall Monitor A said Resident #1 sat on the side of his/her bed rocking back and forth, looking down at the floor with pinched lips and appeared angry, Resident #1 abruptly jumped up, ran into the hall and into Resident #2's room, and punched Resident #2 multiple times in the head and arm. Hall Monitor A called a Code [NAME] (behavioral emergency). Hall Monitor B, who was in Resident #2's room (providing 1:1 monitoring for another resident) and Hall Monitor A grabbed Resident #1's arms and tried to pull him/her off Resident #2. Resident #2 was sent out to the hospital for a medical evaluation. The facility census was 177.Based on interview and record review, the facility failed to ensure one resident (Resident #2), in a review of 12 residents, was free from abuse when Resident #1, who was being monitored by staff one on one, entered Resident #2's room by the connecting bathroom and took a power strip cord, labeled with Resident #2's name. Resident #2 confronted Resident #1 about the missing power strip cord. Both residents' voices were raised and Hall Monitor A, the one on one staff, said he/she stood in front of Resident #2 to prevent him/her from entering Resident #1's room. Hall Monitor C entered the room to assist, pulled the power strip cord out from underneath Resident #1's leg and gave it back to Resident #2. Hall Monitor C left the room to locate a cord for Resident #1. Hall Monitor A said Resident #1 sat on the side of his/her bed rocking back and forth, looking down at the floor with pinched lips and appeared angry, Resident #1 abruptly jumped up, ran into the hall and into Resident #2's room, and punched Resident #2 multiple times in the head and arm. Hall Monitor A called a Code [NAME] (behavioral emergency). Hall Monitor B, who was in Resident #2's room (providing 1:1 monitoring for another resident) and Hall Monitor A grabbed Resident #1's arms and tried to pull him/her off Resident #2. Resident #2 was sent out to the hospital for a medical evaluation. The facility census was 177. Review of the facility's policy titled, Abuse and Neglect, revised on 6/12/24, showed the following:-Abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through technology;-Verbal abuse means the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability. This includes profanity or speaking in a demeaning, nontherapeutic, undignified, threatening or derogatory manner in a resident's presence. Examples include harassing a resident; mocking, insulting ridiculing; yelling at a resident, with the intent to intimidate; threatening residents, including to but not limited to, depriving a resident of care or withholding a resident from contact with family and friends; and isolating a resident from social interaction or activities;-Physical abuse is purposefully, beating, striking, wounding, or injuring any resident or any manner whatsoever mistreating or maltreating a resident in a brutal inhumane manner. Physical abuse includes handling a resident with any more force than is reasonable for a resident's proper control, treatment or management; -The facility will identify events, occurrences, patterns and trends that may constitute mistreatment, exploitation, neglect, abuse, including injuries of unknown source and misappropriation of resident property. Review of the facility's policy, Intensive Monitoring, revised 4/30/24, showed the following:-To ensure a system is in place for residents who required increased monitoring for crisis, behavioral, psychiatric issues.-Residents who require more intensive monitoring due to crisis, behavioral/psychiatric symptoms will be monitored by the facility staff;-One on one monitoring due to crisis, behavioral/psychiatric symptoms will be monitored by facility staff;-Residents who are showing poor impulse control including crisis, behavioral, psychiatric issues such as verbal/physical aggression, elopement ideations, suicidal/homicidal ideations, and decompensation mentally or crisis may be placed on intensive

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the safety of two residents (Resident # 9 and #10) who resided on a locked behavioral unit when a physical altercation occurred between the two residents. Hall Monitor D said Resident #9 came at his/her with fists up and tried to attack him/her. Resident #10 told Resident #9 to leave Hall Monitor D alone. Resident #9 turned around and went after Resident #10 and shoved him/her. Resident #10 shoved Resident #9. The residents shoved each other a second time. Staff working on the hall did not have walkie talkies available, or a functioning intercom system to call a Code [NAME] (behavioral health crisis) to access help. Hall Monitor D had to open the locked door to the unit and yell for assistance. The facility census was 177.Based on interview and record review, the facility failed to ensure the safety of two residents (Resident # 9 and #10) who resided on a locked behavioral unit when a physical altercation occurred between the two residents. Hall Monitor D said Resident #9 came at his/her with fists up and tried to attack him/her. Resident #10 told Resident #9 to leave Hall Monitor D alone. Resident #9 turned around and went after Resident #10 and shoved him/her. Resident #10 shoved Resident #9. The residents shoved each other a second time. Staff working on the hall did not have walkie talkies available, or a functioning intercom system to call a Code [NAME] (behavioral health crisis) to access help. Hall Monitor D had to open the locked door to the unit and yell for assistance. The facility census was 177. Review of the facility's policy, Behavioral Emergency Policy, dated 6/26/25, showed the following:-To provide safe treatment and humane care to the resident in a behavioral crisis, to outline steps to follow to correctly care for the resident in a behavioral crisis, to ensure that the resident is not being coerced, punished, or disciplined for staff convenience;-Care will be guided by the resident's plan of care and based on 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;-Proactive management for our residents is the best plan. All staff should recognize when the resident has become or can become a danger to themselves or someone else. De-escalation techniques should be utilized first;-The licensed nursing staff/and or nursing administration will assess the resident who is displaying crisis, ensuring safety of resident and others is priority. Monitoring of the resident will be initiated, if appropriate. 1. Review of Resident #9's undated Face Sheet showed the following:-The resident admitted to the facility on [DATE];-Diagnoses included mild intellectual disabilities, bipolar disorder (a mental health condition characterized by extreme mood swings), and attention deficit hyperactivity disorder (ADHD, a mental health condition that makes it difficult to resist urges, which can lead to harmful or socially unacceptable behaviors). Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument, completed by the facility staff, dated 4/14/25 showed the following:-The resident understood others and made self-understood;-The resident was cognitively intact;-The resident had clear speech;-No behavioral symptoms exhibited;-Required supervision or touching assistance with activities of daily living (helper provides verbal cues or touching/steading assistance as resident completes activity). Review of the resident's Care Plan, revised 7/2/25, showed the following:-The resident was at risk for alteration in mood related to diagnosis of mood disorder, bipolar disorder, and ADHD. The resident had a history of trouble with concentrating, irritability and rapid mood fluctuations. His/Her behaviors related to mental illness include verbal/physical aggression and can potentially affect others;-Assist the resident, family, caregivers to identify strengths, positive coping skills and reinforce these;-Per the resident's Preadmission Screening and Resident Review (PASARR) Mental Illness Level II Evaluation, the resident reported onset of symptoms when he/she was young which included angry outburst, irritability, difficulty concentrating racing thoughts physical aggression towards others, feelings of worthlessness, threats to harm others, rapid mood fluctuations, mild irritability and increased anxiety;-Intervene as necessary to protect the rights and safety of others. Approach and speak in a calm manner. Divert attention. Remove from the situation and take to alternate location as needed;-Minimize potential for the resident's disruptive behaviors by offering tasks which divert attention;-The resident had a history of behavioral challenges that required protective oversight in a secure setting. Current behaviors: threatens to harm others, angry outbursts, physical aggression. Review of the resident's Nursing Note, dated 7/10/25 at 4:13 P.M., showed the following:-Code [NAME] was called on the resident, when staff got to the unit the resident was standing at the nursing desk talking very loudly and was upset;-When asked what was going on, the resident began to get louder. Staff walked with