

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 07/29/2025
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)
F 0600 Level of Harm - 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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F 0600 Level of Harm - Actual harm Residents Affected - Few	<p>Based on observation, interview, and record review the facility failed to ensure one resident, Resident #5, in a review of 17 sampled residents, was free from abuse when staff physically took the resident down to the ground and caused injury. The resident sustained injuries including a bruised chin, a swollen sprained right ankle, and bruising to the right knee. The resident felt staff abused him/her. The facility census was 177. Review of the facility's Abuse and Neglect Policy, last revised 06/12/24, 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 and resident to resident altercations;-Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish;-Physical abuse: Purposefully beating, striking, wounding, or injuring any resident or any manner whatsoever mistreating or maltreating a resident in a brutal or inhumane manner;-Physical abuse includes handling a resident with any more force than is reasonable for a resident's proper control, treatment, or management;-Physical abuse also includes but is not limited to hitting, slapping, punching, biting, and kicking;-Physical abuse also includes corporal punishment, which is physical punishment used to correct or control behavior. Review of the facility's policy Behavioral Emergency Policy, dated 06/26/24, showed the following:-The facility is to provide safe treatment and humane care to the resident in a behavioral crisis;-Staff is to follow steps to ensure they correctly care for the resident in a behavioral crisis to ensure that the resident is not being coerced, punished, or disciplined for staff convenience;-Any emergency interventions have the potential for (re)traumatizing individuals;-Despite best intentions, decisions concerning the use of physical holds, and the administration of medication are necessarily made under less-than-ideal circumstances (i.e., emergencies), and involve the urgent weighing of significant risks versus the benefits of physical safety;-Therefore, such emergency interventions as the use of physical holds and the administration of medication are to be avoided as possible.-Use of physical holds and the administration of medication is seen as a safety intervention of last resort, rather than a treatment intervention per se, and its usage should be a crisis event;-An organizational philosophy of giving the highest priority to all non-violence is to be articulated in all policies, procedures, and practices;-Practices that are sensitive to those with a history of trauma are to be in place;-Non-Physical interventions are the first choice as an intervention unless safety issues demand immediate physical intervention;-The facility's approved early intervention crisis prevention techniques will be used to de-escalate conflict when possible;-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. Review of the facility's Crisis Assessment Linkage and Management (CALM) training manual, undated, showed the following:-Before beginning a discussion on the use of restraints it is important to consider the potential negative outcomes;-When it becomes necessary to physically control a client, the risk of physical and emotional trauma to both the resident and staff member was significant;-Without question the therapeutic relationship would suffer;-Careful consideration was necessary before involving the use of restraints;-Methods to prevent the use of restraint needed to be included in the policies as well as the expected behaviors of staff members;-Control positions, Seclusion or Restraint are never to be used for punishment. Review of the facility's Crisis Prevention Institute (CPI) training manual, dated 2023, showed the manual included no direction for staff to physically take a resident to the floor. 1. Review of Resident #5's Preadmission Screening and Resident Review, dated 09/14/21, showed the following:-Diagnoses included watershed brain damage (occurs when blood flow is reduced or blocked in the border zones between the major arteries supplying the brain) from seizures at the age of five years old, bipolar disorder (periods of mania and depression), anxiety, impulse control disorder, major depressive disorder, attention deficit and hyperactivity disorder (ADHD), oppositional defiant disorder (ODD is a condition where a person is defiant/argumentative), borderline intellectual functioning (having a low IQ);-The resident had self-harming behaviors and was aggressive with staff;-The resident has poor impulse control;-The resident can be verbally and physically aggressive towards the staff and others and required supervision;-The resident required behavioral therapy two times per week;-The resident required a Crisis Plan that should identify clear steps that will be taken to support individual during a crisis, specify who to contact for assistance, how staff should work together with individual during the crisis, as well as identify when the physician, emergency medical services and/or law enforcement should be contacted.-The facility may also wish to utilize DMH Behavioral</p>		

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F 0658 Level of Harm - Actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow physician's orders and administer medications for three residents (Resident #15, #12, and #17) in a review of 17 residents. Resident #15 had diagnosis of congestive heart failure (CHF) and missed several doses of medications for fluid retention prior to a hospitalization for fluid overload. Resident #12 experienced increased pain from missing ordered pain medications. The facility reported their pharmacy had not supplied the medications. Many of the medications were available in the facility's eKit (emergency medication supply), but staff did not use the available medications to ensure resident's received administration of ordered medications. The facility census was 177. Review of the facility's policy Transcription of Orders/Following Physician's Orders, dated 05/18/24, showed the following:-The purpose of this policy is to outline procedures in accurately transcribing physician's orders and to ensure that all physicians' orders are followed. To ensure a process is in place to monitor nurses in accurately transcribing and following physician's orders;-Upon receiving a physician's order via telephone, fax, written order, verbal order, transcribed order or other, it will be documented in residents' electronic medical records in orders section;-The Licensed/Registered Nurse will check the emergency kit to verify if the medication is present in the facility to begin immediately. If the medication is not available, the facility may contact the backup pharmacy to deliver the medication sooner. If the medication is unable to be started within 24 hours of the order, the prescribing physician will be notified, and further orders will be obtained. If a stat medication is ordered, the physician will be made aware of facility availability in the case that an alternative is needed;-The Licensed Nurse will review electronic Medication Administration Records (MARs) & electronic Treatment Administration Records (TARs) on a routine basis to monitor for medications that were not administered to the resident due to unavailability, refusal, omission, etc.-If a medication is marked as not given, the reasoning for not being given should be explained in the progress notes and the RCC, the DON/ADON/RN, and the Administrator must be notified. The Physician and Legal Guardian (if applicable) must also be notified. The nurse's 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/TARS: The medication will be documented as not given by selecting the corresponding chart code for the reason why it was not given, and a progress note will be written.-If the medication is unavailable, the Licensed Nurse will contact the pharmacy and have the medication delivered. If the resident is not going to receive their scheduled medication per Physician's Order, the Licensed Nurse will contact the Director of Nursing, The Administrator, Physician and Legal Guardian, if applicable. The RCC/Unit Manager/Designated Nurse will then follow any further orders that may be provided by the Physician.-The facility may utilize a stat or emergency medication kit or back up pharmacy to deliver the medication to the resident before the primary pharmacy can deliver.-The Nurse or CMT in charge of medication administration must review all their designated MARs and TARs prior to the end of their shift to ensure that all medications/treatments scheduled to be given on their shift were administered according to the physicians' order and that all necessary interventions were taken in the event of an omission.-The RCC/ Unit Manager/Designated Nurse will review all electronic MARs/TARs and compare all medications to the medications available for each resident in the facility weekly to ensure availability. Review of the facility's Emergency medication list (E-kit) inventory dated 07/24/25, showed the following available medications:- Bupropion (medication for depression) 75 milligram (mg) one on hand;- Cardizem (medication for blood pressure, irregular heartbeat) 30 mg six on hand;-Clonazepam (medication for seizures and anxiety) 0.5 mg seven on hand;-Clonazapine (antipsychotic medication) 0 on hand;-Depakote Sprinkles (medication for seizures sometimes used as a mood stabilizer): DR 250 mg five on hand, ER 250 mg six on hand, ER 500 mg five on hand, sprinkles 125 mg six on hand and DR 500 mg seven on hand;-Farxiga (medication for heart failure, diabetes, and kidney failure) not available;-Furosemide (medication used to remove excess fluid) 20 mg eleven on hand;-Lyrica (medication used for nerve pain) 50 mg 15 on hand;-Metformin (medication used to control blood sugar) 500 mg seven on hand;-Metolazone (medication used to remove excess fluid) not available;-Montelukast (medication to treat seasonal allergies) not available;-Pantoprazole Sodium (medication to reduce stomach acid) not available;- Potassium (medication to replace potassium) 10 milliequivalent (mEq) six on hand;-Pravastatin (medication used to lower cholesterol) not available;-Spironolactone (medication which helps the kidneys remove excess salt and water from the body while retaining potassium) not available;-Sacubitril-Valsartan</p>		

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F 0742 Level of Harm - Actual harm Residents Affected - Few	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. (continued on next page)		

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F 0742 Level of Harm - Actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to recognize behavior triggers and provide early interventions of coping skills for two residents (Residents #13 and #14), in a review of 17 sampled residents, with mental disorders and who lived on a secured behavioral unit. Staff witnessed both residents in an argument during a smoke break and did not intervene or initiate coping skills. The residents left the smoke room and a verbal altercation ensued which led to a physical altercation where the residents hit each other. Resident #13 hit Resident #14 over the head with a laptop computer. Resident #14 obtained a laceration to his/her nose, a swollen and bruised eye, and an abrasion over his/her eyebrow. Resident #13 sustained a laceration on his/her finger. The facility census was 177. Review of the facility's Behavioral Emergency Policy, dated 06/26/24, showed the following:-The facility is to provide safe treatment and humane care to the resident in a behavioral crisis;-The facility's approved early intervention crisis prevention techniques will be used to de-escalate conflict when possible;-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. 1. Review of Resident #13's Preadmission Screening and Resident Review (PASSAR), dated 08/13/20, showed the following:-The resident had a long history of aggression;-Diagnoses included attention deficit hyperactivity deficit (ADHD - a chronic condition including attention difficulty, hyperactivity and impulsiveness), conduct disorder, schizophrenia (mental illness with racing thoughts and hallucination and/or delusions), mild intellectual disorder, bipolar disorder (mental illness with mood swings from manic to depressive), mood disorder, post-traumatic stress disorder (PTSD; a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event); -The resident had delusions, confusion, and history of auditory hallucinations;-The nursing facility needed planning and case management to handle an immediate crisis;-Work with resident to develop a safety plan;-Plan should identify clear steps that will be taken to support individual during a crisis situation, specify who to contact for assistance, and how staff should work together with individual during the crisis. Review of the resident's Care Plan, last revised 04/22/25, showed the following:-The resident was at risk for alteration in mood related to diagnoses that include schizophrenia; -Goal: The resident will not cause harm to self or others through next review;-Behaviors included verbal aggression, physical aggression, poor insight, judgement, and impatience;-The resident suffered from auditory and visual hallucinations and was delusional;-If you see the resident exhibiting any behaviors listed in this section, refer to preferred coping skills and redirect behavior immediately;-Re-direct as able/needed to encourage positive behavior choices;-One-on-one intensive monitoring as needed/warranted for protective oversight;-One-on-one visits as needed/requested for verbalization and ventilation of concerns/feelings;-The resident's safety plan included reminding the resident of his/her diagnosis, validating his/her feelings, and allowing him/her to color;-Triggers for the resident were cigarettes, loud environment, and peers arguing/fighting;-If you observe a trigger happening to the resident, immediately refer to resident's preferred coping skills and redirect behavior;-Coping skills: Listens to music, talking with peers, doing his/her or peer's hair, walking, finding a quiet space/going to his/her room, and calling his/her family support;-If the resident was having behaviors and preferred coping skills were NOT effective, refer to CALM (Crisis Alleviation Lessons and Method, program for managing behaviors), de-escalation protocols. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment completed by staff, dated 06/12/25, showed the following:-Cognitively intact;-No hallucinations, delusions, or behaviors directed toward self or others. Review of the resident's Nurses Notes, dated 07/23/25 at 6:38 A.M., showed residents (Resident #14 and another peer) were in the smoke room talking about how they thought some of their cigarettes were missing. They were not saying anyone's name, but the resident (Resident #13) thought they were talking about him/her. The peer (Resident #13) said something to the other residents about he/she had not stolen anything. One of the residents (Resident #14) told him/her (Resident #13) they were not talking about him/her. Resident #13 left the smoke room. The resident went into a peers' (Resident #18) room to talk to the peer. A few minutes later, peer (Resident #14) that was in the smoke room came into the room and called the resident (Resident #13) a name. A code green (facility alert for a behavioral crisis required response from staff) was called. Resident #13 struck Resident #14 with an object and Resident #14 struck Resident #13. Support staff arrived and residents were separated. Resident #13</p>		