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	08/13/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 0684 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 observation, interview and record review, the facility failed to provide necessary treatment and services for wound care for two residents (Residents #9 and #10) in a review of 22 sampled residents. Resident #9 was being treated for trauma wounds on his/her left foot. Resident #10 was being treated for diabetic pressure wounds on both of his/her feet. The facility did not adequately assess and document the condition of the residents' wounds, clearly identify the sites of the wounds, and failed to ensure the residents arrived at outside wound clinic appointments. Staff failed to complete dressing changes as ordered. Staff failed to ensure residents followed the non-weight bearing status as ordered by the physician and failed to notify the physician when the residents were noncompliant with physician orders. Staff allowed Resident #9 to cleanse the wound on his/her foot during a dressing change without ensuring appropriate infection control methods were followed. The facility census was 174. Based on observation, interview and record review, the facility failed to provide necessary treatment and services for wound care for two residents (Residents #9 and #10) in a review of 22 sampled residents. Resident #9 was being treated for trauma wounds on his/her left foot. Resident #10 was being treated for diabetic pressure wounds on both of his/her feet. The facility did not adequately assess and document the condition of the residents' wounds, clearly identify the sites of the wounds, and failed to ensure the residents arrived at outside wound clinic appointments. Staff failed to complete dressing changes as ordered. Staff failed to ensure residents followed the non-weight bearing status as ordered by the physician and failed to notify the physician when the residents were noncompliant with physician orders. Staff allowed Resident #9 to cleanse the wound on his/her foot during a dressing change without ensuring appropriate infection control methods were followed. The facility census was 174. Review of the facility's Wound Care policy, dated 5/18/24, showed the following:-The purpose of the policy is to promote wound healing of various types of wounds, it is the policy of the facility to provide evidence based treatments in accordance with current standards of practice and physician orders;-Wound treatments will be provided in accordance with physician order, including the cleansing method, type of dressing, and frequency of dressing change;-Treatments will be documented on the Treatment Administration Record or in the electronic health record;-The effectiveness of treatments will be monitored through ongoing assessment of the wound. Review of the facility's Notifying Clinicians policy, dated 6/26/24, showed the following:-The purpose of the policy is to ensure the clinicians are properly notified of a resident's change in condition and overall health and/or mental status;-Examples included new wounds, changes in wounds, poor intake, medication refusal, and anything regarding a change in the resident's baseline or condition;-The nurse will initiate verbal communication with the clinician when a condition or incident arises with a resident which would warrant an immediate implementation of a change in plan or care to include physician advisement or initiation of physician orders to avoid a delay in treatment that may cause worsening in condition. 1. Review of Resident #9's undated Face Sheet showed the resident had diagnoses that included pressure ulcer (localized skin and soft tissue injuries that develop due to prolonged pressure exerted over specific areas of the body, typically bony areas of the body) of left heel, chronic osteomyelitis (bone infection), unspecified site, methicillin resistant staphylococcus aureus infection (MRSA, a bacteria that causes infections in different parts of the body, the most common being the skin and subcutaneous tissues, that are resistant to many antibiotics and is spread by contact and can be followed by invasive infections like osteomyelitis). Review of the resident's Report of Consultation (A document the facility sends with residents to appointments and the physician can send orders/notes back to the facility), dated 6/25/25, showed the following:-Appointment was at the hospital wound clinic;-Non-weight bearing to left foot at all times;-Daily hydrogel (a medical grade gel that creates a moist wound environment and is water-swellable, allowing it to absorb exudate (drainage) yet remain gel-like until saturated) and gauze dressing changes to left heel and first and fifth toes;-Return to clinic in two weeks (7/10/25). Review of the resident's Physician Order Sheet (POS), showed an order, dated 6/30/25, daily gauze dressing to first and fifth toes on left foot. Apply hydrogel and gauze. The POS did not include the complete order sent from the physicians office to include hydrogel to the left heel. Review of the resident's Treatment Administration Record (TAR), dated July 2025, showed the following:-Encourage resident to stay off left foot at all times and be non-weight bearing when up, every four hours; -Apply a single layer of calcium alginate to wound bed and cover with 4x4 gauze. Wrap with kerlix (sterile gauze that is absorbent, breathable, and protective, primarily used for wound dressings)

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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 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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0742 Level of Harm - Actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to ensure one resident with mental disorders (Resident #3) of 22 sampled residents, received individualized treatment and services to meet the resident's needs. The facility failed to implement interventions consistent with Resident #3's plan of care to address his/her behaviors and psychosocial needs. The resident refused medications off and on for a few months and became easily irritated and aggressive. This resulted in verbal and physical altercations with other residents. On 8/10/25, the resident threatened a staff member and another resident got involved. A physical altercation occurred between the two residents and Resident #3 sustained a fracture of the medial orbital wall (eye socket nearest the nose) on the right side. Staff failed to consistently identify the root cause for the resident's behaviors and implement interventions to meet the resident's psychosocial needs. The facility census was 174.Review of the facility policy Behavioral Health Services, dated 10/13/24, showed the following:-The purpose of the policy is to ensure all residents receive necessary behavioral health services to assist them in reaching and maintaining their highest level of mental and psychosocial functioning;-Mental disorder is a syndrome characterized by a clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational or other important activities;-Non-pharmacological intervention refers to approaches to care that do not involve medications, generally directed towards stabilizing and/or improving a resident's mental, physical, and psychosocial well-being;-Behavioral health encompasses a residents' 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;-The facility must ensure behavioral health services are provided;-The facility will ensure that necessary behavioral health care services are person-centered and reflect the resident's goals for care, while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety;-Conditions that are frequently seen in residents and may require the facility to provide specialized services and supports based upon residents' individual needs, include, but are not limited to depression, anxiety and anxiety disorders, schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves that can cause hallucinations, delusions and disorganized thinking including paranoia), and bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs);-The facility utilizes the comprehensive assessment process for identifying and assessing a resident's mental and psychosocial status and providing person-centered care. The assessment and care plan will include goals that are person-centered and individualized to reflect and maximize the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety;-Staff will monitor the resident closely for expression or indication of distress, evaluate whether the resident's distress was attributable to their clinical condition and demonstrate that the change in behavior was unavoidable; assess and develop a person-centered care plan for concerns identified in the resident's assessment, share concerns with the Interdisciplinary Team (IDT) to determine underlying causes of mood and behavior changes, including differential diagnosis, accurately document the changes, including the frequency of occurrence and potential triggers in the resident's record, ensure appropriate follow up assessments if needed, and evaluate resident and care plan routinely to ensure the approaches are meeting the needs of the resident;-The care plan shall have interventions that are person-centered, evidence based, trauma informed, and in accordance with professional standards of practice;-Non-pharmacological interventions include exercise, individualizing sleep and dining routines, supporting the resident through meaningful activities that match his/her individual abilities, interests and needs, focusing the resident on activities that decrease stress and increase awareness of actual surroundings, such as familiar activities, offering verbal reassurance, especially in terms of keeping the resident safe and acknowledging the resident's experience is real to him/her, assisting residents with access to therapies, such as psychotherapy, behavior modification, cognitive behavioral therapy, and problem solving therapy, and providing support with skills related to verbal de-escalation, coping skills, and stress management. 1. Review of Resident #3's undated face sheet showed the resident had diagnoses that included insomnia (inability to sleep) due to other mental disorders, unspecified psychosis (a mental state where a person loses contact with reality, experiencing symptoms like hallucinations (seeing or hearing things not there) and delusions (false beliefs), along with disorganized

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (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 0880 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 observation, interview and record review, the facility failed to use appropriate infection control procedures for hand hygiene to prevent the spread of bacteria or other infections for two residents (Resident #9 and Resident #10) in a review of 22 sampled residents. Staff failed to utilize the appropriate personal protective equipment (PPE), including gowns, when providing care for Residents #9 and #10 who required Enhanced Barrier Precautions (EBP, an infection control intervention designed to reduce transmission of multi-drug-resistant organisms (MDROs) that employs targeted gown and glove use during high contact resident care activities). The facility also failed to post EBP signage outside the door and provide PPE near the room for one sampled resident (Resident #9). The facility census was 174. Based on observation, interview and record review, the facility failed to use appropriate infection control procedures for hand hygiene to prevent the spread of bacteria or other infections for two residents (Resident #9 and Resident #10) in a review of 22 sampled residents. Staff failed to utilize the appropriate personal protective equipment (PPE), including gowns, when providing care for Residents #9 and #10 who required Enhanced Barrier Precautions (EBP, an infection control intervention designed to reduce transmission of multi-drug-resistant organisms (MDROs) that employs targeted gown and glove use during high contact resident care activities). The facility also failed to post EBP signage outside the door and provide PPE near the room for one sampled resident (Resident #9). The facility census was 174. Review of the facility's policy Enhanced Barrier Precautions, dated 5/18/24, showed the following:-It is the policy of the facility to implement enhanced barrier precautions (EBP) for the prevention of transmission of multidrug-resistant organisms (MDROs);-Standard precautions are used with all residents, such as hand hygiene, cleaning equipment, and proper injection procedures. Personal protective equipment (PPE) is used as part of standard precautions when there is an expectation of possible exposure to infectious material;-Contact precautions are used to prevent the spread of germs by contact from an individual with known or suspected infection;-EPB is a strategy in nursing homes to decrease transmission of Center for Disease Control and Prevention (CDC) targeted and epidemiologically important MDROs when contact precautions do not apply. EBP uses PPE and recommends gown and glove use for certain residents during specific high-contact resident care activities associated with MDRO transmission. EBP expands the use of PPE beyond situations in which exposure to blood and body fluids is anticipated. EBP uses gowns and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. EBP does not involve resident room restriction;-All staff receive training on EPB upon hire and at least annually and are expected to comply with all designated precautions;-All staff receive training on high risk activities and common organisms that require enhanced barrier precautions;-Wounds that require EBP are chronic wounds, including, but not limited to pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers. These are wounds that generally require a dressing. Any wound care requires EBP;-Make gowns and gloves available immediately near or outside of the resident's room. Review of the facility's policy Hand Hygiene, dated 6/26/24, showed the following:-All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors;-Hand hygiene is a general term for cleaning your hands by handwashing with soap and water or the use of an antiseptic hand rub, also known as alcohol based hand rub (ABHR);-Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice;-The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. 1. Review of Resident #9's undated Face Sheet showed the resident had diagnoses that included pressure ulcer (localized skin and soft tissue injuries that develop due to prolonged pressure exerted over specific areas of the body, typically bony areas of the body) of left heel, chronic osteomyelitis (bone infection), unspecified site, methicillin resistant staphylococcus aureus infection (MRSA, a bacteria that causes infections in different parts of the body, the most common being the skin and subcutaneous tissues, that are resistant to many antibiotics and is spread by contact and can be followed by invasive infections like osteomyelitis). Review of the resident's Care Plan, dated 7/2/25, showed the following:-The resident had osteomyelitis (infection of the bone);-The resident had a venous/stasis ulcer to the left heel. Observation on 8/11/25 and 8/12/25 showed the resident's room did not have Enhanced Barrier Protection signage or a PPE cart outside the resident's room throughout either day. Observation on 8/12/25 at 9:05 A.M. of Resident #9's left foot