

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 12/04/2025
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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review, the facility failed to notify one resident's guardian (Resident #1) of eight sampled residents regarding the extent of the resident's injuries and upcoming surgery after the resident was in a physical altercation with another resident. The facility failed to notify the guardian the resident was transported by ambulance to a hospital to be evaluated by an orthopedic specialist, or the results of the evaluation which showed the resident sustained a right humeral fracture (a break in the upper arm bone) that required surgical repair. The facility census was 174. Review of the facility policy, Notification of Changes, undated, showed the following:-The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician, and notifies, consistent with his/her authority, the resident's representative when there is a change requiring notification;-Circumstances requiring notification included accidents resulting in injury, potential to require physician intervention;-Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health mental or psychosocial status that may include life-threatening conditions, or clinical complications;-Circumstances that require a need to alter treatment such as acute condition change or a transfer or discharge of the resident from the facility;-Residents incapable of making decisions: the representative would make decisions that have to be made, and the resident should be told what is happening to him/her. 1.Review of Resident #1's undated face sheet showed the resident had a legal guardian. Review of the resident's progress note, dated 11/28/25 at 10:33 P.M. and completed by Licensed Practical Nurse (LPN) J, showed staff called a Code [NAME] (behavioral emergency) on Resident #1 and another resident. When staff arrived, the resident was on the floor and the other resident (Resident #2) was already removed from the situation by staff. The resident was immediately assessed and had red marks on the left side of his/her forehead, and right elbow slightly red with no swelling at the present time. Rates pain in his/her right elbow an 8, on a 0 to 10 scale with 10 being the worse possible pain. The resident said he/she was unable to bend his/her right elbow. Received order to send out via transport for further evaluation. Legal guardian emergency line called and spoke with on call person and notified of altercation and that resident was being sent out to be evaluated. Review of the resident's emergency room discharge instructions dated 11/29/25 at 5:13 A.M., showed the following:-Diagnosis of nondisplaced spiral fracture of shaft of right humerus (a break in the upper arm bone where the fracture line wraps around the bone, but the broken bone pieces remain in good alignment);-Orthopedics will call you to schedule a follow-up appointment to evaluate your arm fracture further and discuss surgery. Record review of the resident's medical record showed no evidence facility staff notified the resident's guardian of the transfer by ambulance to a hospital to be evaluated by an orthopedic specialist, the results of the evaluation, or the follow-up appointment to be set-up to discuss surgical repair for a humeral fracture. During an interview on 12/4/25 at 12:25 P.M., LPN J said the following:-He/She called the emergency on call line for the guardian on 11/28/25 after the incident occurred and left a voicemail regarding the altercation, the resident's complaint of right arm pain, and the plan to transfer to the hospital for evaluation;-Hospital staff normally notified the guardian of any findings while the resident was at the hospital or a transfer to an outside hospital for evaluation. During an interview on 12/4/25 at 8:55 A.M., the resident's guardian said the following:-Staff did not notify him/her of the resident being involved in an altercation;-He/She would expect to be notified immediately of a fall with injury, a transfer to the hospital, fracture of the right arm, and any plans for a surgical procedure;-He/She would have contacted the resident if he/she had been notified of the fracture. During an interview on 12/11/25 at 10:20 A.M., the emergency guardian on-call staff N said on 11/28/25 he/she was on call and the facility did not leave a voicemail or notify him/her of the resident's altercation with injury. During an interview on 12/4/25 at 1:58 P.M., the Administrator said the following:-He would expect facility staff to follow the policy on change of condition and notification;-He would expect staff to notify the guardian of the resident being transferred by ambulance to another hospital for evaluation of the resident's right arm pain, the right arm fracture and any other orders or changes.</p>		

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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)

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F 0600 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 ensure one resident, (Resident #1), in a review of eight sampled residents, was free from abuse when Resident #2 pushed Resident #1 to the ground and kicked Resident #1's head while Resident #1 was down. Resident #1 was sent to the emergency room for right arm pain and was diagnosed with a nondisplaced spiral fracture of the right humerus (a spiral break in the upper arm). The facility census was 174. The administrator was notified of the past noncompliance on 12/04/25, which occurred on 11/28/25. Immediately after the incident, the facility placed Resident #2 on one-on-one monitoring. The facility began their investigation into the allegation and in-serviced staff on duty at the time on abuse, behavioral health services and behavioral emergency policies. Behavioral mediation agreements were completed with both residents. All other staff were to be in-serviced before the start of their next shift. Resident #1 was sent out for medical evaluation. This deficiency was corrected on 12/1/25. Review of the facility's Abuse and Neglect Policy, last 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 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 mistreating a resident in a brutal or inhumane manner;-Physical abuse also includes, but is not limited to hitting, slapping, punching, biting, and kicking. 1.Review of Resident #1's undated face sheet showed the following:-Diagnoses included schizophrenia (a mental health condition that affects how you think, feel and behave), post-traumatic stress disorder (PTSD, a mental health condition that's caused by an extremely stressful or terrifying event), autistic disorder (a neurological and developmental disorder that affects how people interact with others, communicate, learn and behave), schizoaffective disorder, bipolar type (a chronic mental illness blending symptoms of schizophrenia with mood swings), generalized anxiety disorder, and attention deficit hyperactivity disorder (a condition that can make it hard for a person to sit still, control behavior and pay attention). Review of the resident's Preadmission Screening and Resident Review, dated 6/18/25 showed the following:-Historical and current psychiatric and intellectual disability (ID) and developmental disability (DD) diagnoses included schizophrenia, unspecified mood disorder, autistic disorder, pervasive developmental disorder (severe impairments in social interaction, communication and behavior affecting how a child develops and processes information), learning disorder, anxiety disorder, Asperger's disorder (a condition that affects how people see others and socialize with them), Tourette's disorder (neurological disorder causing involuntary repetitive movements or sounds), ADHD, PTSD, mild intellectual disability (limitations in intellectual functioning);-Behaviors in the last 30 days included being intrusive, invades others' space, cursing/swearing, injures self;-Psychosocial assessment showed assistance needed to complete activities of daily living, medical treatment and/or monitoring for chronic conditions with treatment services needed on a regular basis in nursing facility setting, 24-hour protective oversight needed due to severity of behaviors or mental illness symptoms. Individual cannot be without supervision at any time. Review of the resident's care plan, dated 11/28/25, showed the following:-The resident had a history of PSTD; this affected the resident's symptoms and may flare up without any known trigger. Alterations in reactivity from the traumatic even, including aggressiveness, and self-destructive behavior;-Encourage the resident to verbally identify current ineffective coping techniques. Help the resident understand their current behaviors that may be preventing healing or treatment and establish trust with the resident. Listen to what the resident is saying and behave in a calm manner, especially when resident has a high level of anxiety, establishing trust can help the client calm down and make treatment more effective;-The resident is at risk for signs and symptoms related to anxiety disorder including, cursing, nervousness, restlessness and sweating. Be aware of your body stance and facial expressions when you approach the resident. Closely watch the resident for signs of anxiety and act before the resident loses control. Do not argue or tell the resident that they are wrong when he/she is upset;-The resident is at risk for aggression, anxiety cannot make decisions; delusions (fixed false beliefs, that can't be reasoned with), hallucinations (hearing, seeing, feeling, smelling things that are not there) and irritability due to schizophrenia;-On 11/28/25 the resident was involved in a physical altercation with another peer resulting in the resident sustaining injuries. Review of the resident's progress note, dated 11/28/25 at 10:33 P M</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review, the facility failed to follow physician orders for a mechanical soft diet (foods that are chopped or ground to be easily chewed and swallowed to prevent choking) for one resident (Resident #8), who had a history of choking and was on an assist to dine program, when staff prepared and served the resident a regular diet tray including pork loin for the resident's lunch on 11/30/25. The resident choked while eating the meal and became unresponsive and stopped breathing. Staff began cardiopulmonary resuscitation (CPR, an emergency lifesaving procedure that is done when someone's breathing or heartbeat has stopped) and called Emergency Medical Services (EMS). The resident was transferred to the hospital where he/she later expired, with a cause of death of food aspiration (the accidental inhalation of food or liquids into the airway), respiratory failure (insufficient oxygen to the lungs), with unspecified hypoxia (insufficient oxygen reaching the body's tissues, vital organs or the brain). The facility census was 174. On 12/4/25 the Administrator was notified of the past noncompliance IJ that occurred on 11/30/25. The facility began an investigation and corrective measures on 11/30/25. Education was completed on diet policy, supervision of dining rooms, and preparation of therapeutic diets. The facility initiated a system of pictures of all three meals showing therapeutic diet consistencies which were sent to and approved by the dietary manager prior to serving any meals. Dietary staff send a daily menu to all units showing alternatives for all regular and mechanically altered diets. All food substitutions will be approved by the dietary manager. The facility began daily briefings regarding diets/meals between the dietary manager and charge nurse/Director of Nursing (DON). Menus are sent to all units and posted on each unit, followed by documented communication from charge nurse/DON to floor staff of any changes. The facility reviewed all resident's diagnoses, diet orders, and aspiration risk on 12/1/25. The IJ was corrected on 12/1/25. Review of the facility's policy, Supervision of Dining Rooms, Cleanliness and Preparedness of Dining, revised 5/23/24, showed the following:-To ensure that all residents are provided the prescribed diet by the physician and that accurate intakes of food are recorded;-The charge nurse and/or designated department head, and or designated nursing staff assigned to the dining room, will supervise and ensure dining rooms are adequately staffed to direct self-help dining procedures; to ensure that each resident is served the correct ordered physician diet; to ensure that each resident receives enough food; to ensure that each resident eats in a manner consistent with his/her developmental level and ensure that each resident eats in a upright position, unless otherwise specified by the interdisciplinary team or a physician; -Prior to serving the tray the nurse assistant or department head must first read the card to ensure that the resident will receive the correct tray, diet and fluids are placed on the tray;-If any question or if the tray is incorrect, the charge nurse or Registered Nurse supervisor must be notified immediately, and the tray will not be served until corrected. Review of the facility's policy Transcription Orders/Following Physician's Orders, revised 5/18/24, showed the purpose of this policy is to outline procedures in accurately transcribing orders and to ensure that all physician's orders are followed. Review of the facility's Diets policy, revised on 7/5/23, showed the following:-Nursing will check all diet orders received to see that they coincide with diets available;-The physician will be notified if there is any discrepancy to ensure appropriate accommodation to facility diets ordered;-Therapeutic diets are prepared and served as prescribed by the attending physician;-Therapeutic diets are planned, prepared, and served with supervision or consultation from a registered dietician;-Persons responsible for therapeutic diets have sufficient knowledge of food values to make appropriate substitutions when necessary;-A therapeutic diet is defined as any deviation from the regular diet;-The charge nurse is responsible for clarifying diet orders when necessary;-Mechanical soft (chopped);-Mechanically altered diets are planned, prepared and served with supervision of a registered dietician. 1. Review of Resident #8's undated face sheet showed the following:-The resident had a guardian;-Diagnoses included hypoxia with respiratory failure, gastroesophageal reflux disease without esophagitis (a chronic digestive disorder where stomach acid frequently flows back into the esophagus (connection between the mouth and stomach) and personal history of sudden cardiac arrest (sudden loss of heart function, breathing and consciousness). Review of the resident's registered dietician assessment for swallow recommendations, dated 5/9/25, showed the following:-Diet, mechanical soft;-The resident was an aspiration risk (at risk for inhaling material like food or fluids into the lungs) and an assist to dine (dining area staffed by a licensed nurse and certified nursing aides to monitor and assist residents who have been identified as an aspiration risk);-The resident was to empty his/her mouth before the next bite, take small bites, slow down, and remain upright for 30-60</p>		