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	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Village Park	2041 Silva Lane Moberly, MO 65270

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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 - Immediate jeopardy to resident health or safety 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** Based on interview and record review, the facility failed to ensure one resident (Resident #13), in a review of 16 sampled residents, was free from abuse by Housekeeper N. Resident #13 had diagnoses that included personality disorder (mental health condition characterized by long-term, rigid, and unhealthy patterns of thinking, feeling, and behaving that differ significantly from cultural norms), major depressive disorder, recurrent severe without psychosis (a collection of symptoms that affect the mind, where there has been some loss of contact with reality) and severe methamphetamine use disorder. The resident reported to his/her emergency contact that he/she had observed Housekeeper N smoking methamphetamine (a powerful, illicit, stimulant that is highly addictive and can cause anxiety, paranoia, agitation, stroke or death and is typically snorted, smoked or injected), out of a glass pipe in a facility shower room, and the resident approached Housekeeper N about the methamphetamine. Housekeeper N then provided methamphetamine to the resident on four occasions. The resident tested positive for methamphetamine at a pre-operative surgical appointment on 02/12/26. The facility census was 171. The administrator was notified on 02/18/26 at 3:40 P.M. of an Immediate Jeopardy (IJ) which began on 02/08/26. The IJ was removed on 02/13/26, per surveyor onsite verification. Review of the facility policy, Abuse and Neglect, dated 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 abuse and certain resident to resident altercations;-As part of the resident social history assessment, staff will identify residents with increased vulnerability for abuse or who have needs and behaviors that might lead to conflict. Review of the facility policy, Illegal Drug Use, dated 12/27/24, showed the following:-The facility is an illegal drug-free facility;-Illegal drugs are defined for the purpose of this policy as the use, possession or distribution of any substance which is unlawful under the Controlled Substance Act;-No one is allowed to possess, be under the influence of, or use any of said illegal drugs on the premises of the facility;-No one is allowed to sell, buy, transfer, distribute or use said illegal drugs on the premises of the facility;-No one is allowed to sell, buy, transfer, distribute or use any drug paraphernalia (equipment that is used to produce, conceal, and consume illicit drugs) on the premises of the facility. Review of the facility policy, Code of Conduct, dated 04/18/25, showed the following:Controlled Substances:-The facility prohibits the unlawful possession, use, manufacture or distribution of illegal drugs and alcohol on its property or as part of any of the facilities it manages sponsored activity;-All employees shall refrain from illegal conduct in both personal and business matters. 1. Review of Resident #13's Pre-admission Screening and Resident Review (PASARR), dated 10/31/25, showed the following:-Numerous hospitalizations for suicidal ideations;-History of possession charges;-Prison release in 2022;-Endorsed methamphetamine use disorder, severe intravenous (IV) drug use;-Suicide attempts: endorsed three to four times, most recently reported attempted (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	drug overdose which failed followed by attempted hanging with a belt;-The resident was living at a homeless shelter prior to discharge;-The plan is for inpatient physical therapy (PT)/occupational therapy (OT) and then to a long-term care facility to finish antibiotics and then return to the community. Review of the resident's undated Face Sheet showed the following:-The resident admitted to the facility on [DATE];-The resident was his/her own responsible party;-His/Her diagnoses included severe methamphetamine use disorder, stimulant use disorder, antisocial personality disorder, and major depressive disorder. Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 11/23/25, showed the following:-Cognitively intact;-No behaviors or rejection of care;-Taking antibiotic, antipsychotic, antianxiety, antidepressant, and anticonvulsant medications. Review of the resident's Care Plan, dated 12/13/25, showed the following:-The resident has a history of stimulant dependence;-Monitor for cravings and relapse warning signs;-Encourage participation in recovery programs;-Teach coping and stress-management skills;-Assess the resident for safety;-The resident uses psychotropic medications;-Administer psychotropic medications as ordered by the physician. Monitor for side effects and effectiveness every shift;-Behaviors per PASARR:1.Substance abuse;2. Homelessness;3. Paranoid/suspicious of others;4. Suicide attempt;5. Suicidal ideations;6. Methamphetamine intoxication/psychiatric hospital stay 09/21/25;7. History of possession of illegal substances charges;8. Expressed thoughts of self-harm;9. Depression/mania/anxiety;10. History of incarceration/prison;11. Antisocial personality disorder. Review of the resident's February 2026 Physician's Orders showed the following:-Abilify (antipsychotic medication) 10 milligrams (mg) by mouth two times daily;-Biktarvy (anti-viral medication) 30-120-16 mg by mouth once daily;-Celebrex (medication used to treat mild to moderate pain and inflammation), 200 mg by mouth once daily;-Gabapentin (medication used to treat nerve pain and manage partial-onset seizures), 400 mg by mouth three times daily;-Tizanidine (muscle relaxant) 2 mg by mouth two times daily;-Seroquel (antipsychotic medication) 200 mg by mouth daily. Review of the resident's Progress Notes, dated 02/12/26 at 6:28 P.M., showed the following:-Resident scheduled for surgery this morning;-Staff received report the resident was unable to have surgery due to positive urine drug screen;-When resident returned to the facility, assessment and vital signs obtained;-Resident was very tearful at that time. Review of the resident's Progress Notes, dated 02/12/26 at 6:38 P.M., showed the following:-Contacted Psychiatric Nurse Practitioner (NP) to notify her the resident's scheduled surgery was canceled due to a positive methamphetamine result on the drug screen obtained at the appointment;-NP provided an order for hydroxyzine (antihistamine medication used to treat itching from allergies and managing anxiety and tension), 50 mg by mouth twice daily as needed for 14 days for anxiety;-Suicide precautions (safety measures designed to prevent self-harm in high-risk individuals, involving constant, direct observation (1:1), removal of dangerous items (belts, cords, sharp objects and medication) and securing the environment) initiated per facility protocol; -Staff assigned to maintain continuous line-of-sight supervision. Review of the resident's Urine Drug Screen (UDS), dated 02/12/26, showed positive for methamphetamine. Review of the facility Admin/Registered Nurse Investigation (RNI), dated 02/12/26 at 8:22 P.M., regarding Resident #13 and Housekeeper N, showed the following:-The investigative narrative note showed the facility received a report from the Social Services Director (SSD) who said she was contacted by the resident's emergency contact reporting the resident was unable to undergo a scheduled surgery after testing positive for methamphetamine;-The resident's emergency contact said the resident informed him/her that he/she received methamphetamine from a facility employee, identified as Housekeeper N, and the resident had consumed the substance on 02/08/26;-Housekeeper N denied providing drugs to the resident but documented that he/she refused to take a drug (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	test because he/she used methamphetamine twice within the past 30 days;-The resident provided a statement alleging Housekeeper N, and no one else, provided him/her methamphetamine four to five times over a two-week period, delivering small amounts in clear bags to his/her bedroom;-The resident said he/she had paraphernalia in his/her room and willingly told administration where it was located;-Confiscated a straw and a few clear bags; -Resident placed on 1:1;-Local police were called and interviewed both Housekeeper N and Resident #13;-Conclusion/Outcomes of the Investigation: -The investigation substantiated serious concern. The employee admitted to recent methamphetamine use and refused drug testing; the resident tested positive for methamphetamine. Given these findings, immediate corrective action was taken, including protective supervision of the resident, notification of law enforcement and Department of Health and Senior Services and termination of Housekeeper N;-This was a result of abuse. Review of the resident's Progress Notes, dated 02/12/26 at 5:29 P.M., showed the following:-Interdisciplinary Team (IDT) met with the resident regarding allegation the resident received methamphetamine from a staff member;-The resident said he/she started receiving drugs from the staff member approximately two weeks ago;-The resident said he/she received multiple baggies from the staff member in a two-week time period and informed IDT where the baggies were located in his/her room and gave consent to search his/her room;-Resident was asked how the relationship with staff started regarding drugs;-The resident said he/she was going into the shower room located on his/her unit when he/she saw a staff member smoking methamphetamine;-The resident said he/she approached the staff member and asked the staff member to bring him/her methamphetamine;-The resident was tearful and apologetic regarding his/her actions and verbalized understanding the risk of potential harm that he/she could have caused him/herself;-Law enforcement called and arrived at the facility to take the resident's statement;-Resident gave consent to the officers to search his/her room, no additional contraband was located, all items were taken into custody for evidence. Review of the resident's Care Plan, revised 02/12/26, showed the following:-The resident tested positive for methamphetamine during routine drug screen prior to having surgery;-Root cause: The resident's mental health challenges, including anxiety, depression, difficulty sleeping, and struggles with substance abuse, made it hard for him/her to manage impulses and make safe choices. These challenges contributed to the resident's decision to use methamphetamine within the facility, despite knowing it could put his/her health and treatment at risk allegedly. During interviews on 02/17/26 at 11:08 A.M. and 02/18/26 at 10:05 A.M., the resident said the following:-He/She had a history of methamphetamine use and he/she had been clean (abstaining from using drugs) for eight months;-Three to four weeks ago, he/she went into the resident shower/bathroom and saw Housekeeper N smoking methamphetamine from a glass pipe; -When he/she saw Housekeeper N smoking methamphetamine, it just made him/her want to do methamphetamine;-A week later, he/she approached Housekeeper N and asked for some methamphetamine;-Housekeeper N brought him/her three to four plastic bags of methamphetamine. Housekeeper N brought the methamphetamine to his/her room;-He/She used the methamphetamine because he/she was bored and using methamphetamine makes him/her feel normal; -He/She last received methamphetamine from Housekeeper N on Sunday, 02/08/26; -He/She had a urine drug screen on 02/12/26, prior to surgery, and tested positive for methamphetamine;-He/She was previously incarcerated due to methamphetamine use and he/she was unsure what would happen to him/her after using and testing positive for methamphetamine. During an interview on 02/17/26 at 2:17 P.M., the resident's emergency contact said the following:-The resident's drug of choice was methamphetamine;-The resident told him/her the last time he/she used methamphetamine was 02/08/26;-When he/she visited the resident on 02/08/26, the resident pointed out Housekeeper N as the staff member who gave the resident methamphetamine;-The resident told him/her that Housekeeper N gave (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	him/her methamphetamine a handful of times;-The resident missed a major surgery on 02/12/26 and all the resident's plans for surgery and rehabilitation were postponed;-The resident's surgery was cancelled because he/she tested positive for methamphetamine;-The resident had been clean for six months. During an interview on 02/18/26 at 8:40 A.M., the Director of Nurses said the following:-The resident's emergency contact reported to the SSD on 02/12/26 the resident got methamphetamine from Housekeeper N;-Staff giving a resident methamphetamine (or any illegal drugs) would be considered abuse. During interviews on 02/17/26 at 3:10 P.M. and 02/18/26 at 2:54 P.M., the Administrator said the following:-Housekeeper N violated the facility's Abuse and Neglect policy and was terminated;-Housekeeper N admitted he/she used methamphetamine while an employee;-Baggies and paraphernalia were found in the resident's room; -The facility substantiated that abuse occurred; -Staff providing a resident with illegal substances would be considered abuse. During an interview 03/03/26 at 9:28 A.M., the resident's physician said the following:-He was aware the resident tested positive for methamphetamine;-It is not good for anyone to use methamphetamine;-The resident took a great deal of medications that deal with neurotransmitters (chemical messengers in the nervous system that influence mood, muscle movement, heart rate and many other functions) which could cause adverse effects when also using methamphetamine;-Staff should not bring illegal drugs in for residents. NOTE: At the time of the abbreviated survey, the violation was determined to be at the immediate jeopardy level J. Based on interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to remove the IJ violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements.At the time of exit, the severity of the deficiency was lowered to the D level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action to be taken to address Class I violation(s).MO2742762

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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 - Minimal harm or potential for 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to perform a thorough review of one resident's (Resident #1) behavioral health emergencies and take steps to develop person-centered behavioral care plans to support the resident's changing behavioral health care needs. The facility failed to and revise behavioral care plans to include effective interventions for the resident. On 1/27/26, the resident was hospitalized after exhibiting behaviors including threatening another resident and throwing a wet floor sign, which injured a staff member. The resident was hospitalized and returned to the facility 1/29/26. There was no documentation of the interdisciplinary team meeting involving Resident #1, including steps taken to determine potential underlying cause of the negative behavior and steps taken to address, including reviewing and revising the resident's individualized care plan interventions based on that determination. On 1/31/26, the resident, who was assessed the day prior as not being an elopement risk, left the secured unit, went to the facility family room, put his/her hand through a glass window, breaking the glass and in an attempt to leave the facility. The resident sustained injuries which required emergency room care for treatment of lacerations, requiring 20 sutures. The resident was then admitted to the psychiatric hospital. The resident returned to the facility on 2/5/26. There was no documentation to show the facility reviewed the incident for underlying causes or developed a person-centered care plan to support the resident's behavioral health care needs related the resident's new elopement behavior. Observation showed the resident left the secured unit on 2/9/26 and went to the front entrance, demanding to leave requiring a behavioral emergency response from staff. Staff failed to notify the resident's physician of the continued behaviors following his/her readmission on [DATE] and failed to timely update the resident's care plan with interventions to address continued behavioral emergencies. The resident had five Code Greens (behavior emergency) called over a 10-day period at the facility. On 1/27/25 he/she had physical aggression towards a staff member, on 1/31/26 he/she was verbally aggressive and self-harmed, on 2/6/26 and 2/9/26 he/she was verbally aggressive and on 2/10/26 during two incidents he/she was verbally aggressive toward other residents. Residents relayed they were fearful of Resident #1 due to the erratic outbursts and not knowing if the resident would hurt them. The facility census was 171.Review of the facility policy, Behavioral Health Services, dated 10/31/2024, showed the following:-It is the policy of the facility to ensure all residents receive necessary behavioral health services to assist them in reaching and maintaining their highest level of mental and psychosocial functioning;-Behavioral health encompasses a resident's 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 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 nursing home 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, 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 (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 expressions or indications of distress, evaluate whether the resident's distress was attributable to their clinical condition and that the change in behavior was unavoidable, utilize Minimum Data Set (MDS, a federally mandated assessment instrument required to be completed by facility staff) and care area assessments, assess and develop a person-centered care plan for concerns identified, share concerns with the interdisciplinary team (IDT) to determine underlying causes of mood and behavior changes, including differential diagnoses, accurately document the changes, including the frequency of occurrence and potential triggers in the resident's record, ensure appropriate follow up assessments, discuss potential modifications to the care plan, and evaluate the 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, culturally competent, trauma-informed, and in accordance with professional standards of practice, provide meaningful activities which promote engagement and positive, meaningful relationships, and meet the needs of the residents. Review of the facility policy, Behavioral Emergency, dated 09/23/25, showed the following:-Care will be directed by the resident's plan of care and will help to respond to difficult behaviors in the safest and most effective way possible;-The Interdisciplinary Team (IDT) will ensure the care plan is updated if appropriate;-The facility will notify the physician and/or the psychiatrist of the behavioral emergency. The guardian, family or responsible party will be notified of the situation, including current status, hospitalization or other specifics;-Proactive management for residents is the best plan;-All staff should recognize when the resident has become, or can become, a danger to themselves or others;-De-escalation techniques should be utilized first;-At regular intervals, the company will review incidents to obtain root cause analysis which will facilitate improvements of care management and further prevention of incidents. Review of the facility policy, Intensive Monitoring, dated 4/30/24, showed the following:-Residents who are showing poor impulse control including crisis, behavioral, psychiatric issues, such as, verbal or physical aggression, elopement ideations, suicidal or homicidal ideations, and decompensation mentally or crisis may be placed on intensive monitoring or one-to-one or two-to-one (within eyesight of staff) monitoring at the discretion of the administrative staff or facility supervisor;-The facility's interdisciplinary team will address the resident's behavioral concerns and ensure interventions are in place to address residents' needs (psychiatry follow up, counseling, medical needs, etc.). 1. Review of Resident #1's Pre admission Screening and Resident Review (PASRR, a federally required assessment to evaluate individuals for serious mental disorders and/or intellectual disability so that these individuals be offered the most appropriate setting for their needs and those individuals receive needed services in these settings) dated 12/10/18, located in the resident's electronic health record containing only odd numbered pages, one through 15, for a total of eight pages, showed the following:-The resident had a legal guardian;-The resident had psychiatric diagnoses of schizophrenia, psychosis, major depressive disorder, and mood disorder;-The resident was confused at times during the day and night;-The resident had short term and long term memory loss;-The resident had a history of wandering without knowing where he/she was;-The resident had poor judgement and insight;-The resident did not make good decisions;-The resident had below average intellectual functioning;-The resident was easily frustrated;-The resident had difficulty interacting appropriately and/or communicating effectively with others;-The resident manifests agitation;-The resident required interventions by mental health and or judicial systems;-The resident would benefit from recreational (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	therapy/activities evaluation, grief/loss/adjustment counseling/emotional support, medical and psychiatry follow up, development of personal support networks, and monitoring to change inappropriate behavior or alter manifestations of psychiatric illness. Review of the resident's complete PASRR (16 pages provided by the state agency), dated 12/10/18, showed additional information about the resident that would assist in directing his/her plan of care), as follows: -The resident had substantial cognitive impairment;-The resident needed medication therapy, administration and monitoring, and outpatient psychiatric follow up;-The resident required a secured behavioral unit due to his/her short term memory problems, poor insight and judgement, and insistence on leaving the facility. The resident wanted to go home but did not know where home was;-The resident had a history of auditory and visual hallucinations;-The resident had a history of drug and alcohol abuse;-The resident had periods of assaultive behaviors and agitation;-The resident required monitoring at a skilled nursing facility level to ensure safety and needed a structured environment due to his/her memory problems would pose a risk to his/her safety in a less restrictive setting. Review of the resident's Care Plan, dated 4/17/25, showed the following:-The resident displays manifestations of behaviors related to his/her mental illness that may create disturbances that affect others. These behaviors include verbal aggression;-Assist the resident in addressing root cause of change in behavior or mood as needed;-If the resident disturbs others, encourage him/her to go to a more private area to voice concerns/feelings;-Non-pharmacological interventions include meet with administration/staff member the resident is comfortable with, encourage the resident to attend outdoor activities, play music, and provide one-on-one time to talk to a trusted person/staff;-The resident displays impaired thought processes related to a traumatic brain injury;-The resident had confusion and forgetfulness at times;-Monitor and document the resident's behaviors as needed. Report significant changes in cognitive functioning to physician promptly;-Ongoing assessment for changes in mental status, behavioral emergencies and impaired cognitive functioning to physician promptly;-One-on-one intensive monitoring as needed/warranted for protective oversight;-Assist the resident in using coping skills as needed;-Attempt to ascertain what the resident would accept/need to calm down and provide as able;-The resident had triggers that included yelling, being denied toilet paper, and smoking;-Staff and peers should avoid following triggers. If staff observe a trigger is happening to the resident immediately refer to the resident's preferred coping skills and redirect his/her behavior;-The resident had current behaviors that included agitation, mood swings, anxiety and aggression;-If staff see the resident exhibiting behaviors listed in the current behaviors section, refer to the preferred coping skills immediately;-The resident's coping skills include watching tv, sleeping, visiting with peers and group activities;-If the resident is having behaviors and preferred coping skills are not being effective refer to Crisis Alleviation Lessons and Methods (CALM, a system of interventions including de-escalation and physical holds to manage residents in crisis), de-escalation protocols (this protocol had not been used by the facility since 2024 but remained part of the resident's plan of care);-This is my (the resident's) safety plan: not sure;-Please list my personal goal not sure;-I feel like my warning signs are yelling, not being listened to;-My past crisis moments include none;-These are items I want to work on nothing;-The resident was at risk for elopement;-Smoking was not listed as a coping skill for the resident. Review of the resident's quarterly Minimum Data Set (MDS, a federally mandated assessment instrument required to be completed by facility staff), dated 1/6/26, showed the following:-The resident's cognition was moderately impaired;-The resident had no inattention, disorganized thinking, hallucinations, or delusions;-The resident had no physical, verbal or other behaviors towards others. Review of the resident's Progress Note, dated 1/27/26 at 4:02 A.M., showed the following:-The resident (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	approached the nurse's station yelling and using profane language toward staff;-Staff immediately removed any items from the nurse's station that could potentially be thrown;-A peer located down the hall was yelling at and antagonizing Resident #1;-The resident redirected his/her attention toward the peer and began moving in the peer's direction;-Staff immediately intervened by positioning themselves between the resident and the peer, with another staff member standing next to the resident;-A Code [NAME] (behavioral emergency requiring staff intervention) was initiated;-The peer retreated into his/her room and another staff member stood in the peer's doorway to maintain separation between residents;-The resident then threw a wet floor sign directly at staff, striking the staff member in the face;-As additional support staff arrived, the resident moved to the front of the nurse's station and was calm at that time;-911 called. The fire department and police arrived first, followed by EMS (emergency medical services). EMS assessed the injured staff member and transported the staff member to the hospital for further evaluation;-The resident became aggressive again and the police placed the resident in handcuffs and escorted him/her out of the building to the psychiatric hospital;-The resident refused vitals and a skin assessment;-The Director of Nurses (DON), Administrator, primary care physician, and psychiatric nurse practitioner were made aware. Call placed to the guardian's emergency number and was told to leave a voice mail for the guardian. An email was sent that included the progress note;-The nurse spoke with the physician at the psychiatric hospital. Review of the resident's Registered Nurse Investigation (RNI), dated 1/27/26, showed the following:-Date and approximate time of incident: 1/27/27 at 2:30 A.M.;-Type of incident: Physical aggression not involving head;-Persons involved: Resident #1 and Resident #4;-On 1/27/24 an incident occurred involving Resident #1, resulting in staff injury. Resident #1 was observed yelling loudly in his/her room, creating a disturbance on the unit. Staff initiated interventions to maintain safety, including blocking off the nurse's station. Resident #1 then exited his/her room and began moving down the hallway, continuing escalated behavior. He/She was observed was observed threatening staff and verbally aggressive. Staff members followed Resident #1 in an attempt to de-escalate the situation and prevent further disruption. As Resident #1 approached the hallway near Resident #4's room, staff positioned themselves between Resident #1 and other residents to prevent confrontation. During this time, Resident #1 picked up a wet floor caution sign and threw it down the hallway. The sign struck a staff member in the face, causing the staff member to fall to the floor. A green alert was immediately initiated. Resident #4 had returned to his/her room at the time the sign was thrown and was not struck. Resident #4 later reported that prior to the incident, Resident #1 has been threatening staff and verbally provoking Resident #4, stating phrases such as, you want to fight, while advancing down the hallway. Staff intervened by positioning themselves between the two individuals. The wet floor sign initially struck Resident #4's arm and face before striking the staff member allegedly;-Police, physician, guardian notified;-The incident occurred due to unpredictable resident behavior. Staff responded promptly by intervening, initiating emergency protocols, and preventing further escalation. Ongoing focus will remain on de-escalation strategies. It was deemed that Resident #4 was never harmed or put in harm's way. Resident #4 was not close to the resident who struck staff and was roughly 20 yards away;-Residents immediately separated. Allowed 1:1 time to vent and verbalize feelings. Interdisciplinary (IDT) meeting in progress. Peer meeting completed. Education on abuse/neglect. Skin assessment complete. No injections. No missed medications. No abnormal labs. PASSR reviewed. Resident reviewed by primary care physician (PCP). Counseling offered. Legal guardian/PCP/Psych/Management/Administrator all notified;-The plan of care must reflect new interventions as the result of this behavior emergency crisis. List two interventions: See above;-Signed by the administrator as the person completing (continued on next page)

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	265330	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Village Park	2041 Silva Lane Moberly, MO 65270

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the investigation and dated 1/25/26. Review of the resident's Care Plan, listed as Resolved and dated 1/27/26, showed the following:-Problem: RESOLVED. The resident displayed physical aggression, resulting in an investigation;-Desired outcome: protective oversight will be maintained through the next review (2/24/26);-Interventions included residents immediately separated, Resident #1 was allowed one-on-one time to vent and verbalize feelings, the IDT team meeting was in progress, P2I2 (psychosocial questionnaire for residents) meeting completed, no injections were given, no as needed medications were given, the resident was not placed on a one-on-one monitoring; PASRR was reviewed, the resident was reviewed by the physician, counseling was offered;-The resident's guardian, physician, psychiatrist, management/administration were notified;-This care plan problem was marked as resolved on 2/1/26;-Problem: the resident became physically aggressive towards staff;-Desired outcome: ensure protective oversight is provided through next review and the resident will have fewer episodes of physical aggression by the review date (2/24/26);-Interventions included 911 was called and the resident was transported to the hospital by the police, nurses attempted to assess the resident, but he/she refused;-The resident's guardian, DON, psychiatrist, and administration were notified;-The care plan problem was resolved on 1/27/06. The resident's care plan, progress notes, and RNI dated 1/27/26, showed no documentation of the interdisciplinary team meeting involving Resident #1, including steps taken to determine the underlying cause of the negative outcome and steps taken to address, including reviewing and revising individualized interventions based on that determination. One problem, physical aggression that resulted in injury to staff, was noted as resolved on the care plan on the same day it was initiated and before the resident had returned from the hospital. Review of the resident's Progress Note, dated 1/30/26 at 10:45 A.M., showed the resident had no history of elopement. Review of the resident's Progress Notes, dated 1/31/26 at 9:53 A.M., showed the following:-The resident was in his/her wheelchair at the front of the building;-The resident attempted to get through the door;-When the front door was not opened, the resident went into the family area across from the front office and then staff heard glass shattering;-Staff were with the resident when he/she attempted to get out of the window;-Staff called 911 and asked for police and ambulance to the facility;-The Administrator and DON were called with an update;-Once EMS arrived the resident allowed them to address his/her wound and the resident was transported to the hospital;-The resident's guardian was notified. Review of the resident's Hospital Records, dated 1/31/26, showed the following:-The resident required six sutures to the left ring finger;-The resident required five sutures to the outer side of the left hand;-The resident required four sutures to the left wrist;-The resident required five sutures to the left forearm, 20 sutures total;-The hospital called the facility to discharge the resident back to the facility;-When the resident was prepared to return to the nursing home and staff arrived to transport him/her the resident became violent/explosive and refused to return to the facility;-The facility said the resident was to go to a psychiatric hospital for admission because they did not feel comfortable taking the resident back due to his/her violent behavior and aggression towards staff;-EMS staff were never told about the resident's violent behavior or the need for a psychiatric evaluation. Review of the resident's progress notes, dated 1/31/26 at 11:45 A.M., showed the following:-The facility received a call from the local hospital stating the resident was ready to discharge;-The facility said they told EMS to take the resident to a psychiatric hospital about 30 miles south of the facility;-The local hospital said they could not transport the resident to the psychiatric hospital and that the facility would have to transport the resident;-The DON was notified. Review of the resident's Care Plan, listed as Resolved, dated 1/31/26, showed the following:-Problem: RESOLVED. The resident sustained a self-inflicted injury as a result of breaking a window;-Desired (continued on next page)

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