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	03/04/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview and record review, the facility failed to provide protective oversight for one resident (Resident #5) in a review of nine residents, when Resident #5 eloped through the service hall exit door without staff knowledge. On 2/25/26 at 11:32 A.M., Floor Tech A turned the service hall exit door alarm off, entered the door lock code, exited the door without ensuring a spotter (a second staff member to monitor the exit door while unalarmed) was in place. Floor Tech A did not reenter the building through the service hall exit door but entered through a different door later, leaving the service hall exit door unalarmed. On 2/25/26 at 11:35 AM, Resident #5 entered the service hall from the Hangout (supervised common area used by residents for activities and meals)) passed the vending machines (accessible to residents and staff), and attempted to open the service hall exit door without success. The resident returned at 11:50 A.M., pushed on the door handle and the service hall exit door opened. Resident #5 exited the facility to the back of the building, walked around the south side of the building and approximately two blocks down the street, crossed a four-lane highway within the city limits and sat in the grass at a local coffee shop near dumpsters. Facility staff was unaware the resident exited the building. The local police department notified the facility Resident #5 was at the coffee shop 30 minutes after the resident exited the service hall exit door. The facility census was 165. On 3/4/26 at 12:15 P.M. the Administrator was notified of the Past Non-Compliance which occurred on 2/25/26. On 2/25/26, the Administrator identified Resident #5 eloped from the facility through the service hall exit door. Floor Tech A exited the door prior to the resident and did not ensure a second staff member (spotter) was present and left the door unalarmed. Upon discovery, Resident #5 was located and returned to the facility. The resident was placed on increased face to face monitoring checks and re-evaluated for elopement risk. The resident's physician and guardian were notified, and the resident was evaluated by psychiatric services. The resident was unharmed. Additional interventions were implemented to ensure the resident's verbalized need to see the grass and trees was implemented as well as increased staff monitoring of the resident's location and activity. The service hall exit door was secured as well as all exit doors. Staff were educated on use of the service hall exit door and the number of alarm keys was reduced to the Maintenance Director, the charge nurse, the Director of Nursing and the Administrator. Floor Tech A no longer had a key for the service hall exit door. Floor Tech A and all staff were educated on the procedure of utilizing a spotter when exiting an alarmed exit door and ensuring the exit door was always secured. The deficiency was corrected on 2/26/25. Review of the facility Elopement and Wandering Residents policy, dated 6/12/24, showed the following:-The facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care, addressing the unique factors contributing to wandering or elopement risk;-Elopement occurs when a resident leaves the premises or a safe area without authorization and/or any necessary supervision to do so;-The facility is equipped with door locks/alarms to help avoid elopements;-Alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner;-The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for elopement or unsafe wandering, including identification and assessment or risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks and monitoring for effectiveness and modifying interventions when necessary;-Adequate supervision will be provided to help prevent accidents or elopements;-A social service designee will re-assess the resident and make any referrals for counseling or psychological/psychiatric consults following a resident elopement;-The resident and family/authorized representative will be included in the plan of care;-Staff may be educated on the reasons for elopement and possible strategies for avoiding such behavior. 1. Review of Resident #5's undated face sheet showed the following:-admission date of 11/5/25;-Diagnoses of paranoid schizophrenia (mental illness exhibiting intense irrational belief the person is being watched, plotted against or controlled with delusions or believing others are plotting against them or being persecuted and hallucinations or seeing and hearing things that are not real), chronic pain, and generalized anxiety disorder (intense anxiety). Review of the resident's elopement risk assessment, dated 11/6/25, showed the resident did not have a previous history of elopement or an attempted elopement while at home or in a facility. He/She had not expressed the desire to go home, packed belongings to go home or stayed near an exit door. The resident did not wander. Low risk for elopement. Review of the resident's care plan, dated 11/6/25, showed the following:-The resident was at risk for moving around or frequently getting up and down from the chair, nervousness, pacing on the unit and restlessness related to anxiety disorder. Staff should offer activity to keep from getting bored and provide opportunity to release energy in a healthy way;-The resident was independent with Activities of Daily Living (ADLs) with supervision. Staff should provide protective oversight and assist when needed. Review of the resident's quarterly Minimum Data Set (MDS) a federally mandated assessment instrument, completed by facility staff, dated 12/25/25, showed the following:-Cognitively intact;-No wandering;-No functional limitation in movement;-Independent in ambulation and mobility. Review of the resident's hourly face check documentation (located in the resident's electronic medical record), dated 2/25/26 showed staff documented at 9:41 A.M.,10:40 A.M. and11:45 A.M., the resident was in the building. Review of the resident's nurses' note, dated 2/25/26 at 1:41 P.M., showed the Administrator documented at about 12:20 P.M. administration received a call from the local police department. The dispatcher advised one of the residents was located across the street behind the dumpsters of a local coffee shop. At 12:25 P.M. the Administrator arrived at the location behind the coffee shop and confirmed it was Resident #5. The resident sat behind the dumpster area. Staff called to assist in encouraging the resident to return to the facility. At 12:50 P.M. the resident returned to the facility. A full skin assessment was completed with no immediate concerns noted. Observation on 3/3/26 at 9:30 A.M., showed the service hall exit door was located opposite the dietary employee entrance door and next to a locked walk-in cooler and freezer space. The service hall also contained vending machines accessible to residents and staff from the unlocked Hangout area. The service hall led to two different, locked resident units. The exit door was equipped with a coded keypad used to unlock and release the door and a security alarm. Unlocking the exit door required a key for the alarm box located above the door and a code entry on the keypad attached to the wall beside the door. The exit door opened to a covered area and then opened to the back parking lot and perimeter of the facility with access to a side street. The side street was without sidewalks with business along the street and connected to a four lane highway through town. The coffee shop was across the four-lane highway with no stoplights or crosswalks for pedestrians. During an interview on 3/3/26 at 9:35 A.M. the Assistant Administrator said he/she watched the 2/25/26 video footage of the service hall. At 11:32 A.M. he/she saw Floor Tech A turn the keyed alarm off, enter the keypad code, open the door and exit the facility. There was no spotter near the door monitoring the exit door or turning the alarm back on. At 11:35 A.M. Resident #5 tried the door (pushed down the handle) and it did not open, the resident walked away. At 11:50 A.M. Resident #5 tried the door again, the door opened, and the resident exited the door to the back of the facility. The service hall exit door did not alarm. Floor Tech A did not reenter the facility through the service hall (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	exit door on the video footage. No other staff or resident tried to exit the door on the video footage between the time Floor Tech A exited the door at 11:32 A.M. and Resident #5 exited the door at 11:50 A.M. During an interview on 3/3/26 at 9:50 A.M. the Maintenance Director said the service hall exit door was used for vendor deliveries, access to the trash dumpster located behind the facility, access to the back parking lot and access to the storage unit. The service hall was accessible to residents from the Hanout area. Residents and staff utilized the service hall for the vending machines, access to the kitchen, kitchen storage areas and access to locked resident halls. The service hall exit door required a code entered on a keypad on the wall to unlock the door and required a key to turn the door alarm off prior to opening the door. Staff turned the alarm off first with the alarm key, entered the keypad code and then pushed the handle opening the door. If the door banged shut and bounced off the frame it might not have latched leaving the door unlocked or the mechanism failed at the time and the door lock did not engage when Floor Tech A went out the door. The Maintenance Director was not sure how the door opened when Resident #5 pushed on the handle the second time he/she tried the door. The resident did not have the keypad code. Staff should have a spotter every time staff exited the door or when going in and out the door taking trash to the dumpster or unloading deliveries. During an interview on 3/3/26 at 11:15 A.M. Licensed Practical Nurse (LPN) B said he/she was the charge nurse on 2/25/26. He/She was unaware the resident was missing until the administrator called and said the resident was at the local coffee shop across the road. LPN B went to get the resident who sat in the grass behind the coffee shop near the dumpster. The resident wore shoes, appropriate clothing and a sweater. It was not cold outside or raining. Staff had not reported the resident had any behaviors that morning. During an interview on 3/3/26 at 1:15 P.M. Certified Nurse Assistant (CNA) C said he/she worked the resident's hall on 2/25/26. The resident was his/her normal base line that morning, was on one-hour checks and was not a high risk for elopement. CNA C saw the resident all morning on the hall and in the Hangout. The resident did not normally exit seek. Staff were unaware the resident was gone until the police department called and informed the administrator the resident was at the coffee shop in the grass by the dumpster. CNA C completed the resident face checks on 2/25/26 and saw the resident at 11:45 A.M. in the Hangout while doing rounds. The resident was not in the service hall at 11:45 A.M. During an interview on 3/3/26 at 9:00 A.M. Floor Tech A said the following:-He/She exited the service hall exit door many times per day to dump trash, unload trucks and access the storage building. The service hall exit door required a code entered in the keypad located next to the door on the wall and a key to turn off the alarm located above the door. He/She knew the keypad code and had a key for the alarm on his/her work key ring fastened to his/her jeans while working;-On 2/25/26 after finishing the trash run between 10:00 A.M. and 12:00 P.M., he went out the service hall exit door to his/her car on the south side of the building. He/She entered the keypad code and pushed the door open. He/She thought the door alarm was already off, and he/she did not remember using the alarm key turning the alarm off before exiting the door. The alarm did not sound;-He/She did not reenter the facility through the service hall exit door, he/she came back in the facility through the front door (on the opposite side of the facility as the service hall exit door);-He/She did not have a spotter when he/she exited the door and did not make sure the door was secured and alarmed after exiting the door. During an interview on 3/3/26 at 11:30 A.M. the resident said he/she went to see the green grass, looked both ways before crossing the street and sat in the grass by a dumpster. He/She was not injured, did not like the facility and wanted to go home. He/She tried the door twice and it opened the second time. He/She went out the door, around the building and crossed the street. No one saw him/her leave the building. During an interview on 3/3/26 at 10:00 A.M. and 2:05 P.M. the Administrator said the service hall exit door was used many times per day by staff to access the trash dumpster, receive and unload deliveries and access the storage barn. The exit door had a keypad code to unlock the door and required a key to turn the door alarm off prior to opening the door. Staff should have another staff member present as a spotter before exiting the door to ensure the door remained secured and residents were unable to exit the door when opened and (continued on next page)

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