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	03/26/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one resident (Resident #1), in a review of 42 sampled residents, was free from abuse when Resident #2 struck Resident #1 in the head and face with a closed fist after pinning Resident #1 against the wall in their shared bedroom. Resident #1 sustained injuries including pain, two chipped lower teeth, a laceration to his/her lower lip, and lost a tooth, which required medical treatment. The facility census was 165. The administrator was notified of the past noncompliance on 03/26/26, which occurred on 03/14/26. After the incident on 03/14/26, the facility moved Resident #2 from the shared room to another secured unit, provided one-on-one monitoring for Resident #2, began an investigation of the incident, identified the root cause of the abuse, and in-serviced staff on the facility abuse policy and vape pen (a handheld electronic device used to inhale vapor, commonly containing nicotine) expectations per education, which began for those currently in the building and then before other staff's next shift. This deficiency was corrected on 03/16/26. Review of the facility's Abuse and Neglect Policy, last revised 06/12/24, showed the following:-Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish which can include staff to resident and resident to resident altercations;-Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish;-Physical abuse: Purposefully beating, striking, wounding, or injuring any resident or any manner whatsoever mistreating or maltreating a resident in a brutal or inhumane manner;-Physical abuse also includes but is not limited to hitting, slapping, punching, biting, and kicking;-Residents who allegedly mistreat another resident will be removed from contact with the resident during the investigation. 1. Review of Resident #2's undated face sheet showed the following:-He/She had a guardian;-Diagnoses include schizophrenia (a serious mental illness that affects how a person thinks, feels and behaves), anxiety disorder (persistent, excessive fear or worry that interferes with daily life, going beyond normal stress), and paranoid schizophrenia (a subtype of schizophrenia characterized primarily by delusions and auditory hallucinations). Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 03/10/26, showed the following:-Cognitively intact;-No behaviors;-Independent with walking and transfers. Review of the resident's nursing progress notes, dated 03/14/26 at 1:30 A.M., showed the following:-Staff called the nurse to the hall concerning a resident-to-resident altercation;-The resident was sitting at a table in the dining room;-No apparent injury noted, and the resident appeared calm;-The resident said he/she did not want to talk to his/her roommate (Resident #1), so he/she tried to leave the room. Resident #1 closed the bedroom door, hitting him/her with the door;-He/She became angry, so he/she struck Resident #1 several times in the mouth and head;-Staff immediately separated the resident from Resident #1;-Administration notified and arrangements made to move the resident off the hall;-Root cause appears to be conflict within relationship but also may be connected to a vape pen. Review of the resident's written statement, provided by the facility, dated 03/14/26 at 12:20 A.M., showed he/she and Resident #1 began to argue so he/she tried to leave the room. When he/she got to the (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Actual harm Residents Affected - Few	door, Resident #1 punched him/her in the shoulder and grabbed him/her. He/She pushed Resident #1 away and punched him/her. Review of the resident's nursing progress notes, dated 03/14/26 at 2:02 A.M., showed the resident moved to another locked unit in the facility and was under one-on-one supervision. Review of the resident's nursing progress notes, dated 03/14/26 at 3:44 A.M., showed the resident now states the reason he/she did not want to talk to his/her roommate (Resident #1) was because his/her roommate took his/her vape pen and would not give it back to him/her. Review of the resident's electronic health record (EHR), Psychosocial Post-Incident Impact Questionnaire, dated 03/14/26 at 10:55 A.M., showed the following:-Psychosocial Impact:1. Was resident a witness, aggressor or victim in incident? Aggressor;2. Why were you trying to hurt yourself or others? The resident was not trying to hurt his/her peer, just trying to leave the room;5. What do you feel you could have done differently in the situation? He/She should not have hit his/her peer. He/She should have left the vape pen in the smoke box;. Review of the resident's care plan, updated on 03/14/26, showed the following:-On 03/14/26, Code [NAME] (staff's response to a behavioral emergency) initiated related to physical aggression;-Desired outcome: The resident will maintain behavioral stability with use of coping skills, medication management and supportive approaches by staff. Protective oversight will be maintained;-Immediate action: per reporting nurse, resident was immediately separated from roommate. Administration notified and arrangements made to move resident off the hall. During an interview on 03/24/26 at 2:45 P.M., the resident said the following:-On 03/14/26, he/she and Resident #1 had a disagreement over a vape pen;-Resident #1 had his/her vape pen, and he/she wanted it back;-Resident #1 gave the vape pen back, and he/she attempted to leave the room;-Resident #1 tried to shut the bedroom door, and he/she kicked a chair out to prevent the door from closing;-Resident #1 hit him/her in the shoulder, and he/she blacked out in a fit of rage because Resident #1 hit him/her while his/her back was turned;-After the incident, he/she moved off the unit. 2. Review of Resident #1's undated face sheet showed the following: -He/She had a guardian;-Diagnoses include bipolar disorder (mood disorder that can cause intense mood swings), autistic disorder (a condition related to brain development that affects how people see others and socialize with them), attention deficit hyperactivity disorder (a neurodevelopmental disorder marked by persistent inattention, hyperactivity, and impulsivity), impulse disorder (a mental health condition where individuals struggle to resist impulses or urges) and oppositional defiant disorder (a behavioral disorder characterized by persistent [NAME] of angry/irritable mood, argumentative/defiant behavior, or vindictiveness). Review of the resident's nursing progress notes, dated 03/14/26 at 1:34 A.M., showed the following: -Floor staff called the nurse to the resident's hall concerning a resident-to-resident altercation;-The resident was in his/her room sitting on the bed, visibly upset and stating his/her roommate (Resident #2) struck him/her several times;-A staff member gave the nurse a tooth, and the nurse examined the resident's mouth for injury;-One lower front tooth was broken out, another tooth was loose, and a third tooth was chipped;-The resident had a small laceration inside the lower lip where the resident was missing a tooth;-The resident had multiple red areas to the sides and top of his/her head with one at the left, front hairline that was particularly dark and lightly swollen;-The resident said he/she was trying to talk to his/her roommate who became angry and pinned him/her against the door;-His/Her roommate then began punching him/her in the face and head, knocking his/her teeth out;-The resident said he/she did not hit or kick back at his/her roommate;-Staff immediately separated the resident from his/her roommate and placed him/her with nursing for neurological checks (assessment of the nervous system used to detect changes in the brain function, mental status and physical coordination) and observation;-Staff notified the resident's physician and psychiatric nurse practitioner and received orders from the physician to continue neurological checks and to send to the emergency room if any changes to assessment;-Administrator and guardian notified.Review of the resident's care plan, updated on 03/14/26, showed the following: -Code [NAME] initiated related to physical aggression;-Injuries observed to the resident's lips/mouth at the time of incident and a bruise to left forehead post incident;-Desired Outcome: The resident will (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	maintain behavioral stability with use of coping skills, medication management, and supportive approaches by staff. Protective oversight will be maintained; -Immediate Action Taken: Per the reporting nurse, staff gave him/her a tooth and then he/she examined the resident's mouth for injury. One of the resident's lower front teeth was broken out, another tooth was loose, and a third tooth was chipped. The resident had a small laceration inside his/her lower lip where he/she was missing the tooth. Review of the resident's written statement, provided by the facility, dated 03/21/26, showed he/she was trying to talk to Resident #2 calmy. Next thing he/she knew, Resident #2 had him/her pinned against the door and started punching him/her in the head and knocked his/her teeth out. He/She did not hit or kick back at Resident #2. During an interview on 03/24/26 at 12:10 P.M., the resident said the following:-He/She and Resident #2 were roommates;-He/She and Resident #2 had a disagreement over a vape pen. He/She had Resident #2's vape pen, and Resident #2 wanted it back; -He/She gave the vape pen back and wanted to talk to Resident #2, so he/she went to shut the bedroom door to have a private conversation;-Resident #2 opened the door and pinned him/her between the door and the wall in the corner and started hitting him/her;-He/She lost a tooth and chipped two teeth from where Resident #2 hit him/her in the face and head;-Staff immediately intervened and took Resident #2 out of the room and moved Resident #2 from the hall;-He/She did not want to go to the hospital after the incident occurred but later went when his/her teeth were still hurting. Review of the resident's nursing progress notes, dated 03/14/26 at 2:35 A.M., showed the resident complained of head pain with a pain score of five (out of a zero to ten scale, with zero being no pain to ten being the most pain) and aching. Staff administered as needed medication. Review of the resident's nursing progress notes, dated 03/14/26 at 10:11 A.M., showed a new order received to send the resident to urgent care for unresolved dental pain. Review of the resident's EHR showed a report of consultation for the resident's dental appointment, dated 03/16/26, with recommendations and treatment plan for root canal and crown or extraction of two lower anterior broken teeth. 3. During an interview on 03/26/26 at 12:30 P.M., Hospitality Aide B said the following: -On the night of 03/14/26 around 12:20 A.M., he/she was charting and heard a shuffling sound and heard someone say, staff; -When entering the room, he/she saw both residents were behind the door, and Resident #2 had Resident #1 pinned against the wall in the corner;-As he/she separated the residents, Resident #2 reached over him/her and hit Resident #1 one time; -Hospitality Aide C removed Resident #2 from the room and took Resident #1 to the nurse for evaluation; -Resident #1 told him/her Resident #2 broke his/her tooth. During an interview on 03/26/26 at 12:42 P.M., Licensed Practical Nurse (LPN) A, said the following: -He/She was on another unit and was called to the 100/200 hall when staff called a Code Green;-When he/she arrived on the unit, Resident #2 was sitting in the dining room and Resident #1 was sitting on his/her bed in his/her room;-Resident #2 said he/she was angry and tried to leave his/her room;-Resident #1 shut the door and everything escalated from there;-Resident #1 had a cut inside his/her lower lip where a tooth had cut his/her lip, and had a knocked-out tooth and a couple of chipped teeth;-Staff immediately separated both residents and kept Resident #2 in line of sight until they could move him/her to a different room;-Staff moved Resident #2 to another locked unit;-He/She was told later the altercation was about a vape pen that belonged to Resident #2 that Resident #1 had, and Resident #2 wanted it back. During interviews on 03/26/26 at 8:58 A.M. and email communication on 03/31/26 at 4:18 P.M., the Administrator said following: -Abuse/Neglect education and vape management education began on 03/14/26 and was completed on 03/16/26; -All residents were educated on the vape rules that vapes must stay with the cigarette box and not on their person at any time. Complaint #2804276