

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

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 07/22/2026
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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide medically related social services to attain the highest practical, physical, mental and psychosocial wellbeing and assure adequate social services were implemented for three residents (Resident #9, #10 and #11), in a review of 11 sampled residents. The facility failed to make arrangements for a transfer to another facility for Resident #9 and #11 and failed to assist Resident #11 with transition of care arrangements to the other facility, assuring post discharge medications were available. The facility also failed to provide Resident #10 with a written response of actions taken to resolve his/her grievance. The facility also failed to employee a qualified social worker since 06/22/26. The facility census was 160. During an interview on 07/22/26 at 1:30 P.M. the Administrator said the facility did not have a policy related to social services. She would expect the facility to follow the regulation regarding social services. Review of the facility's policy, titled Grievance Policy-Residents, dated 12/27/24, showed the following:-The facility wants to hear and address any concern of a resident. A resident or their legal representative can bring concerns to a staff member, the resident concern group or call the compliance hotline. Additionally, each resident had the right to use the formal grievance process;-The grievance official is responsible for overseeing the grievance process; receiving and tracking grievances through to their conclusion; leading any necessary investigations by the facility; issuing written grievance decisions to the resident;-The social service director shall serve as the grievance officer and may be reached at the facility address and phone number. If the facility does not have a social service director, the Administrator shall appoint someone to serve as the grievance officer;-The grievance official will take steps to resolve the grievance, and record information about the grievance and those actions on the grievance form;-In accordance with the resident's rights to obtain a written decision regarding his/her grievance, the grievance official will issue a written decision on the grievance to the resident or representative at the conclusion of the investigation. The written decision will include at a minimum the date the grievance was received, the steps taken to investigate the grievance and a summary of the pertinent findings or conclusions regarding the resident's concerns. 1. Review of Resident #9's undated Face Sheet showed the following:-The resident was his/her own responsible party; -Diagnosis of malignant neoplasm (cancerous mass) of esophagus (the muscular tube that carries food and liquid from your throat down to your stomach), secondary malignant neoplasm of the lung and pharynx. Review of the resident's Care Plan, last revised 06/13/25, showed the resident and/or guardian decided they would like to explore other care options or living arrangements, staff would provide information and referral to facility of resident's choice. The resident and his/her family member would like the resident closer to a specific location. During an interview on 07/22/26 at 3:38 P.M. the resident said the following:-The resident found out he/she had terminal cancer and had only (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 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 ensure two residents with mental disorders (Resident #2 and #1), in a review of 11 sampled residents, received appropriate treatment and services to attain their highest practicable mental and psychosocial well-being. Resident #2 had poor insight and judgement, a history of verbal and physical aggression and was at risk for self-harm as indicated on his/her Preadmission Screening and Resident Review (PASRR, a screening for serious mental illness and intellectual or developmental disabilities to ensure the most appropriate placement setting) and Care Plan. Staff failed to provide one on one monitoring, keeping the resident within line of site per the facility policy as one staff was outside the room with the door closed and another staff member was later found to be asleep on the floor while assigned the resident's one on one monitoring following a resident-to-resident altercation where Resident #2 punched Resident #4 on the left side of the face. Resident #4 sustained an abrasion to his/her top lip, scratches to his/her chest and red marks around his/her neck. Staff failed to implement coping skills and interventions, per facility policy and the resident's Care Plan when the resident yelled and pounded on walls and failed to notify the physician of the resident's increased behaviors, timely. The facility also failed to adequately monitor Resident #1 per facility policy and direction from the psychiatric provider following a recent reduction of his/her antipsychotic medication and failed to notify the psychiatric provider when Resident #1 was involved in several Code Greens (behavioral emergencies), exhibited aggressive behaviors and attempted to assault another resident. Resident #1 injured his/her ankle and fell while attempting to assault another resident. The facility census was 160. Review of the facility policy titled, Behavioral Health Services, dated 10/31/24, 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 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 (continued on next page)		

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 titled, 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, titled 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 #2's Preadmission Screening and Resident Review, dated 02/19/21, showed the following:-Psychiatric diagnoses included bipolar affective disorder (a chronic mental health condition characterized by extreme cyclical shifts in mood, energy and activity levels) with severe psychotic features, depressive disorder, dysthymic disorder (a long lasting form of depression characterized by chronic low mood, fatigue and feelings of hopelessness), severe mixed bipolar I disorder (the simultaneous presence of manic and depressive symptoms) and schizoaffective disorder (a chronic mental health condition marked by a combination of symptoms like hallucinations or delusions and major mood disorder symptoms such as depression or mania);-History of drug abuse including methamphetamine and heroin (illicit drugs);-Prior history of suicide attempts. Denied current suicidal ideations;-Records indicated poor insight and judgement;-Impulsive actions and poor decision making skills;-If admitted to a nursing facility, the resident needed behavior monitoring with every 15-minute checks, line of sight recommended when around vulnerable individuals;-The resident's crisis plan should identify clear steps that will be taken to support the resident during a crisis situation, specify who to contact for assistance, how staff should work with the resident during a crisis, as well as identify when the physician, emergency medical services and/or law enforcement should be contacted;-Close monitoring and supervision were needed. Review of the resident's Care Plan, last revised 07/02/25, showed the following:-The resident was at risk for altered mental status and mood swings due to bipolar disorder;-Staff will report any new behaviors to the resident's physician as needed;-Staff will encourage the resident to discuss any negative thoughts;-The resident currently required a secured (continued on next page)		

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	talking recklessly to him/her, staff's tone when approaching him/her about an incident, being asked the same questions over and over again, staff thinking they are better than him/her, others being disrespected;-Triggers are talking to his/her family member on the phone (a handwritten note was added to form under triggers);-Coping skill: CMT J tried to talk to him/her and calm him/her down;-Your one-on-one should always be within arm's reach;-Your responsibility when assigned one-on-one was to provide protective oversight for that individual;-Before taking responsibility for one-on-one, understand the purpose behind the resident being on the one-on-one so that you are fully aware of what you should be monitoring;-Keep in mind that a resident was placed one-on-one due to emergent reasons (falls, altercations, self-harm, etc.) you must take each one on one assignment seriously;-Signing the bottom of the form means you have read the form, understood, and completed the above information. Failure to do so will result in termination due to failure to protect the resident;-Floor Care H, who was assigned to provide one-on-one for the resident, signed his/her name to bottom of the form (indicating he/she read the form and understood and completed the information). Under the section updates, Floor Care Staff H added a hand written note with the words mad, angry and irate, referring to the resident, and signed his/her name. Observation on 07/22/26 at approximately 8:30 A.M. showed the following:-Floor Care Staff H, assigned to provide one-on-one for the resident, was seated on a chair outside the resident's room. The door to the resident's room was closed;-Sounds of heavy pounding on the walls, loud yelling and profanity came from inside the room. Review of the facility's CPI training record showed Floor Care staff H completed CPI training on 08/11/25. During interview on 07/22/26 at 8:36 A.M. and 07/30/26 at 8:36 A.M. and 11:50 A.M., Floor Care Staff H said the following: -The resident was on the phone and had been hitting the wall, crying, and yelling for a while;-He/She questioned the surveyor if he/she should go into the resident's room when the resident was hitting the wall and yelling. He/She knew the resident was on the phone but wasn't sure if he/she should check on him/her;-If the resident got too out of hand, he/she would let someone know; -He/She opened the door about every hour to check on the resident;-He/She was frequently assigned to be on a one-on-one because the facility was short staffed;-He/She knew the resident had been in a fight and could fly off the handle;-He/She was CPI trained; -He/She was not sure how far behaviors should go with the resident before he/she called a Code Green. Observation on 07/22/26 at approximately 8:52 A.M. showed CMT J entered the resident's room and closed the door. Sounds of heavy pounding on the walls and loud yelling continued to be heard from outside of the room through the closed door in the hallway. During an interview on 07/22/26 at 9:02 A.M., CMT J said he/she administered the resident's routine medications and tried to calm him/her down. The resident was on the phone with his/her family member. During an interview on 07/22/26 at 9:06 A.M., Floor Care Staff H said after CMT J administered the resident's medications and talked to the resident, he/she calmed down for a second. Review of the resident's one-on-one form, dated 07/22/26 for 10:50 A.M. through 3:40 P.M., showed the following:-Aggression was the reason for the one-on-one;-Current behaviors included verbal aggression, physically aggressive, pacing, insomnia, anxiety, false allegations, delusions, and defending specific staff;-Triggers: yelling, people laughing in his/her face, people talking recklessly to him/her, staff's tone when approaching him/her about an incident, being asked the same questions over and over again, staff thinking they are better than him/her, and others being disrespected;-Your one-on-one should always be within arm's reach;-Your responsibility when assigned one-on-one was to provide protective oversight for that individual;-Before taking responsibility for one-on-one, understand the purpose behind the resident being on the one-on-one so you are fully aware of what you should be monitoring;-Keep in mind the resident was placed on one-on-one due to emergent reasons (falls, altercations, self-harm, etc.). You (continued on next page)		

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 07/22/2026
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.			
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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	must take each one-on-one assignment seriously;-Signing the bottom of the form means you have read the form, understood, and completed the above information. Failure to do so will result in termination due to failure to protect the resident;-Floor Care Staff C signed the bottom of the form. Observation on 7/22/26 at 2:54 P.M. showed the door to the resident's room was partially open, and the resident was in bed resting with his/her eyes closed. One-on-one staff, Floor Care C, was seated on the floor outside the resident's room with his/her head down and eyes closed. Observation on 7/22/26 at 2:55 P.M. showed Floor Care Staff C was startled when the surveyor asked if he/she was the one-on-one staff for the resident During interview on 7/22/26 at 2:55 P.M., Floor Care Staff C said the following:-Floor Care Staff C quickly stood up and said he/she had dozed off and this was not his/her normal role;-The resident was upset, hitting the walls and yelling, when he/she first started his/her one-on-one assignment around 11:00 A.M.;-He/She was not familiar with the resident's care plan. He/She just kept an eye on the resident. If the resident got irate, he/she made sure the resident did not hurt himself/herself;-He/She had completed CPI training. Review of the facility's CPI staff training record showed Floor Care Staff C completed CPI training on 02/02/26 During an interview 07/23/26 at 11:10 A.M., the resident's family member/guardian said the following: -The facility notified him/her of the altercation on 7/21/26 involving the resident;-The resident needed psychiatric help;-The resident had not been aggressive for a very long time. The resident had routine home visits on the weekends and had been doing very well;-The resident was on the phone with the family member off and on all day yesterday. The resident was very upset yelling and hitting things;-The resident was upset because he/she thought his/her roommate (Resident #4) was talking to his/her boyfriend/girlfriend;-The resident broke his/her hand in the past from hitting the wall when he/she was upset and angry. During an interview on 07/22/26 at 12:20 P.M., Resident #4 said the following:-Resident #2 was his/her previous roommate. He/She was sore from the altercation the day before;-He/She and Resident #2 were in their room alone while two of the housekeeping staff moved things out of the room. There were no other staff in the area;-Resident #2 put his/her hands around his/her neck and tried to choke him/her out. Resident #2 thought he/she had been talking to his/her girlfriend/boyfriend. Staff came running and grabbed ahold of Resident #2;-He/She felt safe while he/she remained on the current hall, but he/she did not want to go on the hall where Resident #2 was located. Resident #2 continued to make threats against him/her;-He/She informed the Assistant Administrator, and he/she said to block the text messages from Resident #2. Review of Resident #4's phone text message from Resident #2, dated 7/22/26 at 6:52 A.M. showed the following;-If nobody was there to keep him/her (Resident #2) off your bitch ass, soft ass he/she would beat him/her so bad he/she would go to jail for life. Fuck you. If Resident #2 crossed him/her (Resident #4) in the hall, the pain he/she had over his/her boyfriend/girlfriend was getting released on him/her (Resident #4);-He/She wished the two of them were on the other side of the fence. During an interview on 07/22/26 at 9:50 A.M., and 07/22/26 at 4:10 P.M. Corporate Support Staff Q said the following:-Resident #2 remained on one-on-one supervision as an intervention;-He had to protect the facility staff, so when the resident was acting out and hitting walls, he/she would not expect staff to enter the resident's room because the resident could hit the staff;-If the resident broke his/her hand, then the resident broke his/her hand. He/She had to protect the facility staff;-The police would not take the resident;-The facility was actively trying to pursue a 96-hour hold for the resident;-The facility had been in contact with Psychiatric Nurse Practitioner I regarding the resident's continued behaviors;-It was clinically inappropriate for staff to enter the resident's room when he was having behaviors;-When the surveyor asked him to elaborate on why, he did not provide a response. During an interview on 07/22/2026 at 2:35 P.M. Registered Nurse B said the following:-He/She was not aware (continued on next page)		

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #2 had been hitting the wall and yelling inside his/her room earlier that day;-The Director of Nursing called RN B around 10:00 A.M. to 11:00 A.M. and told him/her to go check on the resident as he/she was having behaviors;-He/She received an order for Thorazine (antipsychotic medication) intramuscular injection and a drug urinalysis from Psychiatric Nurse Practitioner I. The resident refused the urinalysis;-The primary care physician ordered Benadryl (an antihistamine that can be used to treat insomnia) because the resident said he/she had not slept for a couple days;-Staff should open the door and check on a resident if a resident was hitting the walls and yelling and notify the charge nurse of the behaviors. During an interview on 07/22/26 at approximately 3:35 P.M., the Administrator said she would have expected staff to go into Resident 2's room and check on him/her if he/she was hitting the wall and yelling to assure the resident was safe or call a Code Green. Once she was made aware of Resident 2's behaviors (hitting walls and yelling), she went to the resident's room and checked on the resident. She notified the DON to make sure staff checked on the resident. She expected staff to follow the behavioral health policies. Staff should not ask the surveyor what to do when the resident was hitting the walls and yelling. Staff should not be sitting on the floor or asleep when they provided one-on-one monitoring for a resident. The resident did get upset when someone was in the room all the time. The Assistant Administrator notified her Resident #2 was sending threatening text messages to Resident #4, and the Assistant Administrator instructed Resident #4 to block Resident #2's text messages. During an interview on 07/22/26 at 10:35 A.M., Psychiatric Nurse Practitioner I said the following:-Resident #2 was typically not aggressive. On 07/21/26, staff notified him/her of the physical altercation that occurred on 07/21/26 between the two residents and the facility was working on obtaining a 96-hour psychiatric hold for the resident; -Staff should not leave the resident in his/her room alone with the door closed while the resident yelled and hit the wall;-The door should remain open so staff could monitor the resident to ensure his/her safety;-Staff should call a Code [NAME] or continue notifying the police if they were unable to handle the situation to assure the resident's safety;-On 07/22/2026, at approximately 10:11 A.M. on 7/22/26 the facility notified her the resident was hitting the walls and yelling inside his/her room. She gave staff a verbal order for Thorazine 25 milligrams (mg) and a urine drug screen to be obtained due to his/her aggression and agitation which was not typical for the resident. 2. Review of Resident #1's PASRR, dated 04/06/26, showed the following:-The resident had a chronic history of mental illness with multiple psychiatric diagnoses;-The resident's current hospital admission was precipitated by suicidal ideation and aggressive behavior;-The resident's limitations included impaired judgment, medication non-compliance, impaired impulse control and emotional regulation, history of substance use and intellectual disability;-A crisis plan should be developed to create clear steps to be taken to support the resident during a behavioral health crisis and how to determine when the crisis was over. The plan should also identify a physician and emergency medical services that should be contacted;-The resident needed health behavior assessment and intervention and monitoring of behavioral symptoms. Assess and plan for the level of supervision required to prevent harm to self or others. Review of the resident's Care Plan, last revised 05/13/26, showed the following:-Attention-deficit/hyperactivity disorder (ADHD) related to impaired attention span and impulsivity;-Maintain a structured, consistent daily routine to promote focus;-Monitor behavior and report any significant changes to the provider;-Redirect impulsive or restless behaviors calmly and respectfully;-The resident was at risk for the following signs and symptoms related to diagnosis of bipolar disorder, may change clothes multiple times a day, may display high emotions and low emotions, and may have increased signs and symptoms of depression;-Assist the resident with staying on task;-Be consistent. Keep routine consistent as much as possible;-Calmly redirect (continued on next page)		

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	inappropriate behavior. Decrease stimulation around the resident when the resident displayed signs of anxiety;-Do not get into a power struggle with the resident;-Offer warm baths or soothing music to decrease restlessness;-Provide activities that only require short attention span;-The resident used psychotropic medications related to behavior management;-Administer psychotropic medications as ordered by the physician. Monitor for side effects or effectiveness each shift. Review of the resident's comprehensive MDS, dated [DATE], showed the following:-The resident was cognitively intact;-No behaviors;-He/She received antipsychotic medication. Review of the resident's Mental Status Exam, dated 06/06/26, showed the following:-Seen today for initial psychiatric evaluation and medication management. This was the first encounter with the provider;-The resident reported overall psychiatric stability and denied current mood swings , depression, anxiety, hallucinations, paranoia or other acute psychiatric concerns;-The resident reported compliance with prescribed medications and denied current medication side effects other than excessive sedation from Seroquel (antipsychotic medication). The resident reported the current dose was too much and requested a dose reduction. The resident requested a trial of a lower dose;-Given current psychiatric stability and patient request, a gradual dose reduction trial is clinically appropriate to determine the lowest effective dose while maintaining symptom control;-Monitor closely for recurrence of mood swings, irritability, insomnia, anxiety, psychosis or behavior changes, substance use concerns or safety concerns. Nursing staff to notify psychiatry of worsening mood symptoms, insomnia (common sleep disorder that involves trouble falling asleep, staying asleep or waking up too early) medication, intolerance, behavioral changes, substance use concerns, or safety concerns. Seroquel will be reduced from 150 mg to 100 mg at bedtime with close monitoring for symptom recurrence;-Bipolar disorder current episode manic without psychotic features mild, actively monitoring;-Intermittent explosive disorder (a mental		