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	03/22/2022

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 0562 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide immediate access to any resident. 32899 Refer to Event ID YST412. Based on interview and record review, the facility failed to provide residents' representatives, families, and state representatives timely access to residents by not ensuring telephone calls received through the facility's telephone system were answered and/or messages were returned timely. The facility census was 176. Review of facility's policy, Resident's Rights, last reviewed 4/29/21, showed the following: -The resident has the right and the facility must provide immediate access to any resident by the following; i. Any representative of the Secretary of Health and Human Services; ii. Any representative of the State of Missouri; iii. Resident's individual physician; iv. The State long term care ombudsman; v. The agency responsible for the protection and advocacy system for developmentally disabled individuals. vi. The agency responsible for the protection and advocacy system for mentally ill individuals; vii. Subject to Resident's right to deny or withdraw consent at any time, immediate family or other relatives; viii. Subject to reasonable restrictions and resident's right to deny or withdraw consent at any time, others who were visiting with the consent of the resident; -Facility would provide reasonable access to any resident by any entity or individual that provided health, social, legal, or other services to Resident, subject to Resident's right to deny or withdraw consent time. (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

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	03/22/2022

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F 0562 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident has the right to have reasonable access to use of a telephone where calls could be made without being overheard; -The resident shall be permitted to communicate, associate, and meet privately with persons of his/her choice whether on the resident's initiative or the other person's initiative, unless to do so would infringe upon the rights of other residents. During interview on 3/8/22 at 2:40 P.M., Resident #33 said there was no telephone for residents who resided on the 900 hall to use, they shared a phone with residents on the 800 hall (the 800 hall and the 900 hall are separate secured units). They could never use the shared phone because it was always located on the 800 hall and the battery on the phone was dead. During interview on 3/8/22 at 4:23 P.M., Resident #56 said he/she relied on the facility's phone system for means of communication with his/her family. He/She was unable to speak with his/her family because when his/her family members called the facility, the facility staff would not answer the phone. During interview on 3/8/22 at 11:00 A.M., Resident #40's guardian said the following: -He/She had spent days trying to get through to the facility at times; -The phone would ring endlessly with no answer; -If staff happened to answer the phone and transfer the call, either a voicemail would come on saying he/she could not leave a message as the voice mail box was full or the phone would simply continue to ring; -He/She should be able to reach residents and staff for questions, concerns or just to visit when needed. During interview on 3/16/22 at 11:30 A.M., Resident #24's and Resident #30's guardian said he/she sometimes had difficulty communicating with the facility, because he/she could not get hold of any one via phone. There were some weeks when no one would answer the facility's phone. During interview on 3/8/22 at 9:40 A.M., the Business Office Manager said he/she had spoken with a company to ensure all incoming telephone calls went to the front office from 6:30 A.M. to 11:00 P.M., and after 11:00 P.M., the calls were sent to the units. They were also attempting to make sure voice mail boxes were not full, and if no one picked up after a transfer, the call would return to the reception area. He/She knew there had been a problem lately when a call was transferred to a unit. During interview on 3/8/22 at 6:00 P.M., Certified Medication Technician (CMT) P said the following: -He/She worked the front reception area in the afternoons; -He/She received a lot of complaints from families who said they had tried to get through all day; (continued on next page)

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	265330	A. Building B. Wing	03/22/2022

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F 0562 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She knew the voice mails on the units would say they were full, and the facility was supposed to be working on that. During interview on 3/9/22 at 10:15 A.M.,the Regional Director of Operations said the facility was working on updating and fixing the telephone system. He/She hoped this would help with people being able to contact the facility. A cell phone had been placed on units where there were no phones. The 800 and 900 halls shared a cell phone, and 100, 200, and 300 all have working phones. During interview on 3/15/22 at 2:40 P.M., the administrator said the facility was having problems with the telephone system. The phones system was all messed up. The telephones were not ringing and staff were not able to access their voice mails to retrieve messages. The phones were pretty much behind locked doors (did not indicate a location of these phones). Phones may not even ring. They were training the receptionist to call the requested unit to alert them of an incoming call prior to the transfer so the unit was aware there was a telephone call. He/She had been working with the phone company and trying to get corporate to get a different format for three months. The receptionists had reported they had had complaints from people trying to reach the facility. Guardians, families and physicians should have immediate access to their residents. MO197303

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	265330	A. Building B. Wing	03/22/2022

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 0567 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to manage his or her financial affairs. 32899 U4413 Refer to Event ID YST412. Based on record review and interview, the facility failed to keep residents from going into a negative balance which allowed the residents to spend another resident's money without written authorization for five residents (Resident #5, #6, #7, #8 and #9) out of sample of 10. The facility census was 178 residents. 1. Record review of the facility maintained Trust Statement for the period 09/01/21 through 03/15/22, showed Resident #5 was allowed to go into a negative balance for the following dates: Date Amount 09/14/21 -$50.48 09/15/21 -$90.48 09/15/21 -$120.48 09/17/21 -$130.48 02/04/22 -$30.00 During email correspondence on 03/29/22 at 12:53 P.M., the administrator said Resident #5's Guardian did not send money for him/her which created the negative balance. 2. Record review of the facility maintained Trust Statement for the period 09/01/21 through 03/15/22, showed Resident #6 was allowed to go into a negative balance for the following date: Date Amount 01/19/22 -$49.92 During email correspondence on 03/14/22 at 4:49 P.M., the Business Office Manager said facility staff misread the amount listed on the bank sheet for Resident #6 and allowed the resident to go into a negative balance. 3. Record review of the facility maintained Trust Statement for the period 09/01/21 through 03/15/22, showed Resident #7 was allowed to go into a negative balance for the following dates: Date Amount 03/01/22 -$2.00 (continued on next page)

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	265330	A. Building B. Wing	03/22/2022

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F 0567 Level of Harm - Potential for minimal harm Residents Affected - Some	03/03/22 -$3.00 During email correspondence on 03/14/22 at 4:49 P.M., the Business Office Manager said the facility had to correct the negative balance for Resident #7 since the bank had not cleared a check. 4. Record review of the facility maintained Trust Statement for the period 09/01/21 through 03/15/22, showed Resident #8 was allowed to go into a negative balance for the following dates: Date Amount 02/01/22 -$11.68 02/17/22 -$11.68 02/28/22 -$11.68 03/02/22 -$16.68 During email correspondence on 03/16/22 at 9:04 A.M., the Business Office Manager said Activities over-shopped for Resident #8 which made him/her go into a negative balance. 5. Record review of the facility maintained Trust Statement for the period 09/01/21 through 03/15/22, showed Resident #9 was allowed to go into a negative balance for the following date: Date Amount 03/09/22 -$10.00 During email correspondence on 03/29/22 at 12:53 P.M., the administrator said the facility withdrew money for shopping while Resident #9 also withdrew money.

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	265330	A. Building B. Wing	03/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0568 Level of Harm - Potential for minimal harm Residents Affected - Many	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. 32899 U4413 Refer to Event ID YST412. Based on record review and interview, the facility failed to provide quarterly statements showing the current balance and all transactions for all residents the facility managed funds for. The facility census was 178. 1. Record review of the facility's maintained Resident Trust Account for the period 09/01/21 through 03/15/22, showed the facility could not provide evidence that quarterly statements were sent showing the current balance and all transactions. During an interview on 03/08/22 at 8:13 A.M., the Financial Representative for Residents #2, #3, #4, #5 and #10 said he/she has not received any Quarterly Statements for any of the residents. During an interview on 03/17/22 at 11:06 A.M., the Guardian for Resident #3 said he/she does not receive Quarterly Statements and they should go to the financial representative. During an interview on 03/17/22 at 11:00 A.M., the Guardian for Resident #5 said he/she does not know if his/her office has received any Quarterly Statements but thought it was supposed to go to the financial representative for Resident #5. During email correspondence review on 03/10/22 at 4:45 P.M. the Business Office Manager said quarterly statements only get mailed to the resident's financial representative if it is requested by the financial representative and the resident's guardian approves it. During an interview on 03/17/22 at 11:23 A.M., the administrator said the resident trust quarterly statements should have been mailed to the resident's financial representative but could not prove where the quarterly statements were mailed to.

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	03/22/2022

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32899 Refer to Event ID YST412. Based on observation, interview, and record review, the facility failed to provide a comfortable environment by failing to ensure the residents had hot water (105 degrees to 120 degrees Fahrenheit) available in the rooms/bathrooms. The facility census was 178. Review of the facility hot water temperature testing policy, dated 03/23/20, showed the following: -Purpose: Ensure the facility follows required regulations and tests water temperatures to assure they are maintained within a safe range between 105-120 degrees; -Procedure: The facility maintenance director or designee shall take water temperature sample tests daily Monday through Friday. A minimum of one hot water temperature sample should be taken on every hallway throughout the building in random locations. All testing shall be documented in a log book and any samples out of range shall be reported to the facility administrator immediately. Record review of the facility's resident room water temperature logs, dated 01/26/22, showed the following: -Resident room [ROOM NUMBER] hot water temperature 101.5 degrees Fahrenheit; -Resident room [ROOM NUMBER] hot water temperature 101.3 degrees Fahrenheit; -Resident room [ROOM NUMBER] hot water temperature 101.4 degrees Fahrenheit. Record review of the facility's resident room water temperature logs, dated 01/27/22, showed the following: -Resident room [ROOM NUMBER] hot water temperature 101 degrees Fahrenheit; -Resident room [ROOM NUMBER] hot water temperature 92 degrees Fahrenheit; -Resident room [ROOM NUMBER] hot water temperature 96 degrees Fahrenheit. Record review of the facility's resident room water temperature logs, dated 01/28/22, showed the following: -Resident room [ROOM NUMBER] hot water temperature 101.5 degrees Fahrenheit; -Resident room [ROOM NUMBER] hot water temperature 101.3 degrees Fahrenheit. Record review of the facility resident room water temperature logs, dated 02/02/22, showed the following: (continued on next page)

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	265330	A. Building B. Wing	03/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident room [ROOM NUMBER] water temperature 101.2 degrees Fahrenheit; -Resident room [ROOM NUMBER] water temperature 101.8 degrees Fahrenheit; -Resident room [ROOM NUMBER] water temperature 101.3 degrees Fahrenheit. Record review of the facility's resident room water temperature logs, dated 02/22/22, showed the following: -Resident room [ROOM NUMBER] water temperature 67 degrees Fahrenheit; -Resident room [ROOM NUMBER] water temperature 67 degrees Fahrenheit. Observation on 02/22/22 between 2:15 P.M. and 3:45 P.M. showed the following: -The temperature of the hot water in occupied resident room [ROOM NUMBER] was 88 degrees Fahrenheit; -The temperature of the hot water in occupied resident room [ROOM NUMBER] was 92 degrees Fahrenheit; -The temperature of the hot water in occupied resident room [ROOM NUMBER] was 82 degrees Fahrenheit; -The temperature of the hot water in occupied resident room [ROOM NUMBER] was 85 degrees Fahrenheit; -The temperature of the hot water in occupied resident room [ROOM NUMBER] was 91 degrees Fahrenheit. During interview on 02/22/22 at 2:18 P.M., Resident #6 (who resided on the 300 hall) said he/she had not had hot water in his/her room for a few weeks. He/She did not report it. During interview on 02/22/22 at 2:18 P.M., Resident #8 (who resided on the 300 hall) said he/she had not had hot water in his/her room for a few weeks. He/She did not report it. During interview on 02/22/22 at 2:18 P.M., Resident #9 (who resided on the 300 hall) said he/she had not had hot water in his/her room for a few weeks. He/She did not report it. During interview on 02/22/22 at 2:30 P.M., Resident #41 (who resided on the 300 hall) said he/she had not had hot water in his/her room for about a month. He/She reported it to maintenance about a month ago. During interview on 02/22/22 at 3:45 P.M., the maintenance supervisor said the residents reported no hot water on the 300 hall about two weeks ago. He just had not had a chance to fix it. (continued on next page)

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	265330	A. Building B. Wing	03/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on 02/22/22 at 4:00 P.M. and 04/01/22 at 1:46 P.M., the administrator said staff should report cold water to her and to maintenance staff. Maintenance staff check and document the water temperature in random rooms throughout the facility every Monday through Friday. If the water temperature is not within regulation guidelines, maintenance should report it to her and should start working on the remedy immediately. The maintenance supervisor notified her the 300 hall did not have hot water (on 2/22/22). She informed him to call a plumber and get it fixed. She expected the hot water temperatures to meet regulation. MO197518

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	03/22/2022

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 - 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** 32899 Refer to Event ID YST412. This deficiency is uncorrected. For previous examples, see Statement of Deficiencies dated 12/22/22. Based on interview and record review, the facility failed to ensure one resident (Resident #55), who had a diagnosis of chronic pain, in a review of 38 sampled residents, was free from neglect when Licensed Practical Nurse (LPN) E fell asleep during his/her shift and failed to administer the resident his/her as needed pain medication. As a result, the resident reported his/her pain was a nine (on a scale of one to ten, with ten being the worst pain possible). The facility also failed to ensure residents were free from abuse when Certified Nurse Assistant (CNA) V yelled, cursed and belittled the residents. The facility census was 176. Review of the facility's policy, Abuse, Neglect, Grievance Procedures, dated 11/28/16, showed the following: -It is the policy of the facility that every resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. It is also the policy of this facility that every resident has the right to be free from verbal, sexual, physical, or mental abuse, corporal punishment, and involuntary seclusion; -Mistreatment, neglect, or abuse of residents is prohibited by this facility; -This facility is committed to protecting our residents from abuse by anyone including, but not limited to, facility staff, other residents, consultants, volunteers, and staff from other agencies providing services to the individual, family members or legal guardians, friends, or any other individuals; -The facility abuse prohibition program included screening, training, prevention, identification, reporting/investigating, and protection of the resident. -Class I neglect is defined as failure of an employee to provide reasonable and necessary services to maintain the physical and mental health of any resident when that failure presents either imminent danger to the health, safety, or welfare of a resident, or a substantial probability that death or physical injury would result. -Class II neglect is defined as failure of an employee to provide reasonable or necessary services to a resident according to the individualized/habilitation plan, if feasible, or according to acceptable standards of care. This includes action or behavior, which may cause psychological harm to a resident due to intimidating, causing fear or otherwise causing undue anxiety. (continued on next page)

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	265330	A. Building B. Wing	03/22/2022

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 0600 Level of Harm - Actual harm Residents Affected - Few	-Verbal abuse is defined as using profanity or speaking in a demeaning, non-therapeutic, undignified, threatening or derogatory manner in a resident's presence. Examples include harassing a resident, mocking, insulting, ridiculing, yelling at a resident with the intent to intimidate, and threatening residents. 1. Review of Resident #29's face sheet showed the following: -He/She was admitted to the facility on [DATE]; -His/Her diagnoses included paranoid schizophrenia (mental condition characterized by presence of one or more delusions or auditory hallucinations in a person who seemed to have otherwise relatively normal thinking ability and emotions). Review of the resident's admission Minimum Data Set (MDS), federally mandated assessment to be completed by the facility, dated 1/13/22, showed his/her cognition was intact and that he/she had no hallucinations, delusions, and/or behaviors that affected others in the previous seven-day look back period. Review of the resident's care plan, dated 1/19/22, showed the following: -He/She had impaired thought process related to paranoid schizophrenia; -He/She would participate in decision making for daily tasks of life; -He/She would accept judgement from staff as appropriate; -Staff would approach him/her in a warm, positive, and calm manner; -Staff would calmly talk with him/her and always explain what they would be doing before they did it. Review of the facility's Registered Nurse Investigation (RNI), dated 2/4/22, showed on 2/4/22, the resident reported to the charge nurse that CNA V said he/she was not getting him/her (Resident #29) a fucking thing after the resident asked for a snack. The resident reported that CNA V twisted his/her (Resident #29's) words around, and said I didn't ask if you're fucking yourself. Resident #56 witnessed the event and reported that CNA V said, fuck you, no when Resident #29 asked for a snack. Review of the resident's written statement, dated 2/4/22, showed he/she kept asking CNA V for a snack. CNA V told the resident, I'm not getting you a fucking thing. During an interview on 3/8/22 at 2:47 P.M., Resident #56 said he/she witnessed CNA V say fuck you, no when Resident #29 asked for a snack. CNA V treated him/her and other residents horrible. CNA V cursed and called him/her and other residents names like, bitch, whore, and sluts. CNA V used profanity including the F word. CNA V made him/her feel like a little child. During an interview on 3/15/22 at 11:07 A.M., Resident #29 said the following: -He/She didn't like that CNA V was nasty and made the ugly part of him/her come out; (continued on next page)

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	265330	A. Building B. Wing	03/22/2022

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-CNA V was very abrupt, hateful, and had a bad attitude. During an interview on 3/8/22 at 10:00 A.M., Resident #18 said CNA V cursed at residents. During an interview on 3/8/22 at 2:40 P.M., Resident #33 said CNA V yelled at him/her. CNA V made him/her feel lousy and incompetent. During an interview on 3/8/22 at 2:47 P.M., Resident #31 said CNA V didn't talk nicely to residents. CNA V made him/her feel like shit when he/she spoke to him/her in this way. During an interview on 3/8/22 at 2:47 P.M., Resident #27 said CNA V would get mad at him/her when he/she asked to get a soda. CNA V used curse words when he/she spoke to him/her (the resident). CNA V made him/her feel like shit when he/she spoke to him/her in this way. During an interview on 3/9/22 at 12:00 P.M., Resident #35 said CNA V was hateful, harsh, very rude, and sarcastic to the level of disrespectful of other's integrity. CNA V made him/her feel like shit for even asking for help. CNA V provoked him/her until the point of anger, then he/she (Resident #35) would be in trouble. Administration did not listen to his/her and others' reports of CNA V's provoking behaviors. During an interview on 3/15/22 at 11:25 A.M., Resident #26 said CNA V was rude and mouthy. He/She was so sick of CNA V's mouth. CNA V would say, I'm sick of this and sigh when residents asked for something. CNA V made residents feel like a piece of crumb off of a shoe. During an interview on 3/8/22 at 10:16 A.M., CNA Y said CNA V was rude to everyone. CNA V yelled and cursed at residents. All staff had complained to management about CNA V cursing, screaming, and belittling residents. He/She witnessed CNA V treat Resident #38 like an animal by telling Resident #38 to sit down and shut up. During an interview on 3/8/22 at 2:54 P.M., Nursing Assistant (NA) X said CNA V was rude and did not care about the residents. He/She witnessed CNA V be rude and treat residents like they didn't amount to anything and curse at residents. During an interview on 3/15/22 at 4:40 P.M., Certified Medication Technician (CMT) P said he/she witnessed CNA V yell, curse, call residents names and belittle residents; During an interview on 3/15/22 at 2:40 P.M., the administrator said the following: -On 3/15/22, he/she received an email from Resident #26's guardian stating Resident #26 reported to his/her guardian that CNA V said, what the fuck do you want, bitch to Resident #26 when Resident #26 knocked on the 900 hall door to obtain the phone; -She considered it abusive if staff called residents names with use of both profanity and non-profanity; -She expected staff to talk to residents with dignity and respect and without the use of profanity. 2. Review of Resident #55's care plan, dated 7/7/21, showed the following: (continued on next page)

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	03/22/2022

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 0600 Level of Harm - Actual harm Residents Affected - Few	-Chronic back pain, and fourth and fifth contracted finger pain; -Resident will report new onset of pain to staff promptly; -Ongoing assessment of pain status. Monitor for worsening of pain status; -Administer medications as ordered. Monitor effectiveness and side effects. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Cognitively intact; -Presence of constant pain (rated eight); -Pain affected sleep and day to day activities; -Received scheduled and as needed (PRN) pain medications. Review of the resident's physician's orders, dated February 2022, showed the following: -Diagnoses included pain; -MS Contin (morphine sulfate; narcotic pain medication to treat moderate to severe pain) Extended Release (ER) 15 milligrams (mg) every 12 hours for pain; -Morphine sulfate immediate release (IR) 15 mg every six hours PRN for breakthrough pain. During an interview on 3/22/22 at 5:22 A.M., the resident said the following: -He/She had chronic pain and took scheduled and PRN pain medications; -Last week, he/she had to wait four hours for his/her PRN pain medication after he/she had requested it; -He/She requested the pain medication at 3:30 A.M., and did not receive the medication until around 6:45 A.M.; -His/Her pain worsened (as he/she waited for the pain medication) getting up to a hard nine; -Staff told him/her they could not find the charge nurse. During an interview on 3/22/22 at 5:03 A.M., CNA F said the following: -Resident #55 had requested a pain pill around 2:30 A.M.- 3:00 A.M., and staff could not locate LPN E (on 3/17/22); -He/She went to the other unit to find LPN E, and found him/her behind the nurse's desk (asleep); (continued on next page)

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	265330	A. Building B. Wing	03/22/2022

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-He/She attempted to wake LPN E, but could not; -He/She went a second time to find LPN E and he/she was in the nursing office (behind the desk) asleep and still would not respond. During an interview on 3/22/22 at 5:03 A.M., CNA G said the following: -He/She sent LPN E a message on 3/17/22 around 3:41 A.M. because the resident needed pain medication; -CNA F went over to the other unit and found LPN E asleep; -He/She went to the other unit after CNA F returned, and observed LPN E sleeping in the office (behind the nurses' station); -He/She attempted to wake LPN E as the resident needed pain medication. He/She tried shaking LPN E and placed cold water rags on him/her but was not able to wake him/her. During an interview on 3/22/22 at 11:36 A.M., LPN E said the following: -He/She worked night shift on 3/16/22 as the charge nurse and was responsible for two units (Meadowbrook and Homestead); -He/She was responsible for Resident #55's care; -He/She was responsible for administering PRN medications after 11:00 P.M.; -He/She was not aware the resident was needing pain medication that night; -He/She was not aware staff had searched for him/her due to the resident needing pain medication; -He/She fell asleep (during his/her shift) but did not know what time; -He/She should not sleep while on duty; -Once a resident requested pain medication, the resident should be assessed and the medication administered immediately. Review of the resident's Medication Administration Record (MAR), dated March 2022, showed the resident received Morphine IR 15 mg on 3/17/22 at 7:27 A.M. During an interview on 3/22/22 at 1:30 P.M., the administrator said the following: -She did not learn that LPN E had fallen asleep (during his/her shift) until around 6:00 A.M. (on 3/17/22) when LPN H sent her a text message. She then learned LPN E had slept from midnight to around 6:00 A.M.; -She would not expect staff to sleep while on duty; (continued on next page)

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	265330	A. Building B. Wing	03/22/2022

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-Staff should administer pain medications timely within 10 to 15 minutes. If a resident's pain is greater then five, the nurse would assess the resident; -Although LPN E sleeping and not administering pain medication could be considered neglect, it was not intentional, willful neglect. MO 197906 MO 198598

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F 0742 Level of Harm - 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** 32899 Refer to Event ID YST412. Based on observation, interview and record review, the facility failed to ensure four residents (Resident #23, #24, #3, and #18), in a review of 38 sampled residents with mental disorders who lived on secured behavioral units received individualized treatment and services to meet their needs. The residents displayed verbal and physical behaviors directed toward other residents on multiple occasions. Facility staff identified Resident #23 had anger issues and bullied other residents, including Resident #24, and failed to adequately develop and implement meaningful interventions, including non-pharmacological interventions, alternate strategies, or to ensure the residents received timely and appropriate treatment or services to address the residents' psychosocial well-being before verbal and physically aggressive behaviors occurred. Resident #24 expressed he/she had enough of Resident #23's bullying behavior and decided to stand up for himself/herself (which resulted in additional physical and verbal altercations between the residents). Residents #3 and #18 were involved in two verbal and physical altercations while Resident #3 was on one-on-one direct monitoring. Staff were pulled from all departments, including dietary and housekeeping to sit with residents who experienced behaviors. These staff were not familiar with the residents' history or behavior in order to deescalate behaviors. The facility census was 176. Review of the facility's [NAME] of Focus Program: An Accountability and Responsibility System. A Comprehensive Care Plan for the Mentally Ill, Second Edition 2019, showed the following: -The vision of the program is focused on the individual resident and what accountability and responsibility he/she can achieve in the least restrictive environment; -The direction of the program is focused on helping the individual resident cope with their illness on a day to day basis. The program and its integrity is uniquely designed to assist the resident and their responsible party in achieving individualized goals with an objective measuring tool that is realistic and easy to comprehend; -The program includes physical, mental, medical, spiritual, social, and activities that are individualized to specifically address the resident's holistic being; -The program focuses on the individual resident achieving their maximum level of functioning by utilizing an individual plan of care designed for the resident to be successful in a therapeutic milieu which offers safety and security; -The program allows the resident and staff to be innovative in developing creative individual plans of care that focus on goals and positive outcomes; -The basic philosophy of the [NAME] of Focus is to empower the resident to maintain or make positive life changes while working towards their interdisciplinary individualized plan of care and encourage the resident to work on their GAP (Goals Action Plan) goals; (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	-Each phase of the program encourages the resident to focus on short and long-term goals. These goals become part of the individualized care plan with the resident, legal guardian, and interdisciplinary staff input. As the transition takes on success, the resident begins to feel encouraged to reach for the next phase; -Each resident will have an individual assessment and plan of care that is tailored to intermingle with the resident's assessment tool and will outline limitations and privileges set forth by the legal guardian; -Each week, the legal guardian will receive a weekly star report which will update them on the resident's progress and goals. This allows the legal guardian to be notified with any plan of care changes and provides the legal guardian with the opportunity to provide input or further direction in the resident's voyage; -In the [NAME] of Focus Program the resident will be known as the Captain. Members of the Interdisciplinary Care Plan Team/designated department heads will be known as Co-Captains and assigned to certain residents. For the first 30 days after admission, the resident's Co-Captain will be the Director of Nursing or the Administrator; -The Co-Captain will meet with their assigned Captains daily to discuss their progress, concerns, and positive/negative behaviors; -The Captain's progress will be documented on the daily Star Report; -The Star Program has five key components that will be monitored daily by the resident's Co-Captain: personal hygiene, homelike environment, social skills, covenant guidelines, and plan of care; -Each day the Co-Captain will utilize the five key components to evaluate the resident's progress for the previous day. The resident can be awarded up to seven stars per week. The stars awarded Friday, Saturday, and Sunday, will be evaluated and rewarded on Mondays; -The Co-Captain will demonstrate and indicate whether the resident was successful in the five key areas by placing a star on the resident's MAP (My Action Plan); -The resident will be disqualified from being awarded a star from the previous day if they demonstrate negative behaviors (this does not include decompensation from psychosis); -If a Captain earns a star, two days will be subtracted from their current phase; -If a Captain does not receive a star due to negative behavior, no days will be subtracted from the current phase; -If the Captain does not receive a star due to not meeting the appropriate number of goals, one day will be subtracted from the current phase; (continued on next page)

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	265330	A. Building B. Wing	03/22/2022

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F 0742 Level of Harm - Actual harm Residents Affected - Few	-The Interdisciplinary Team (IDT) and Co-Captains will attend a weekly [NAME] of Focus meeting to review the behavior, care concerns, and resident requests. It is mandatory for all IDT members to attend. The Co-Captain will bring the Daily Star Report to the weekly [NAME] of Focus meetings to discuss changes in the resident's behavior and progress; -The administrator and the Director of Nursing (DON) will be the driver for the weekly [NAME] of Focus meetings. Ultimately, the administrator and DON are responsible for administrating this process. Review of the facility's Behavioral Emergency Policy, dated 2021, showed the following: -The purpose is to provide safe treatment and humane care to the residents in a behavioral crisis, to outline steps to follow to correctly care for the residents in a behavioral crisis and to ensure that the resident is not being coerced, punished or disciplined for staff convenience; -The DON/Assistant Director of Nursing (ADON)/Registered Nurse (RN)/Designee will complete an RN investigation within 24 hours of the behavioral emergency. This may include a PRN (as needed) Intervention Form and notification of state agencies in the event that criteria are met; -In the event the resident is unable to be redirected or is requesting an as needed (PRN) medication for mood stabilization, the resident will be given PRN medication per physician's orders. If the resident receives a PO (by mouth) PRN mood stabilizing medication, the licensed nurse must complete the PRN Intervention Form. If the resident receives an IM (intramuscular, injection given in the muscle) PRN for mood stabilization a RN Investigation will be completed including the PRN Intervention Form; -The licensed nurse will document the behavioral emergency in the medical record by utilizing the BIRPEEEE documentation guidelines; -B= Behavior Emergency - define behavior -I= Intervention - document intervention, note behavior emergency policy and document interventions from the behavioral emergency policy; -R= Reaction/Response - document reaction and response of the resident after the interventions; -P= Plan - continue current plan of care, continue observing and monitoring of the resident; -E= Evaluation; -E= Evaluation; -E= Evaluation; -E= Evaluation; -Documentation of the behavior emergency in the RN Investigation will include evaluation of the resident's behavior, including consideration for precipitating events or environmental triggers, (continued on next page)

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	265330	A. Building B. Wing	03/22/2022

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F 0742 Level of Harm - Actual harm Residents Affected - Few	and other related factors in the medical record with enough specific detail of the actual situation to permit underlying cause identification to the extent possible, not identifying or attempting to identify the root causes of the behaviors and not revising the plan of care with measurable goals and interventions to address the care and treatment for a resident with behavioral and/or mental/psychosocial -All Behavioral Emergency Code [NAME] Reviews filled out by the responding staff will become part of the RN investigation to ensure that the behavioral crisis was handled professionally, that it could not have been avoided, and was handled by CALM certified staff using appropriate techniques, following policies of the facility. -Following the Behavioral Emergency Policy is vital and all areas that the Behavioral Emergency Policy addresses must be clearly understood and documented. Review of the facility's undated one-on-one (1:1) staff reminders showed the following: -You must stay with your 1:1 resident; -Your responsibility when assigned a 1:1 is to provide protective oversight for that individual; -Before taking responsibility for a 1:1, understand the purpose behind the 1:1 oversight so that you were fully aware what you should be monitoring for; -Keep in mind that a resident was placed on 1:1 monitoring due to emergent reasons (falls, altercations, self-harm, etc.). 1. Review of Resident #30's Pre-Admission Screening and Resident Review (PASRR) evaluation (a federal assessment utilized to ensure individuals who have a mental disorder or intellectual disabilities are not inappropriately placed in nursing homes for long-term care), dated [DATE], showed the following: -He/She had history of abuse and neglect by parents and unstable childhood; -His/Her diagnoses included bipolar affective disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), schizoaffective disorder (mental disorder characterized by abnormal thought processes and an unstable mood), borderline personality disorder (illness marked by an ongoing pattern of varying moods, self-image, and behaviors often result in impulsive actions and problems in relationships), oppositional defiant disorder (mental disorder characterized by a pattern of angry antagonistic, hostile, negative, irritable, and/or vindictive behaviors), and post-traumatic stress disorder (PTSD, mental disorder that developed after experiencing and or witnessing terrifying or life-threatening event); -The resident presented to the emergency room at 36 weeks pregnant on [DATE]. C-section (surgical removal of baby) was performed, he/she was cleared medically, and admitted to psychiatric unit. The child was taken into protective custody. (continued on next page)

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	265330	A. Building B. Wing	03/22/2022

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F 0742 Level of Harm - Actual harm Residents Affected - Few	-He/She had a history of numerous hospitalization s, both inpatient and outpatient; -Recommended the resident received mental health services from a therapist who would work with him/her consistently; -The resident should be evaluated regularly to determine ability to transition to less restrictive place. It was recommended that transition to less restrictive placement be incremental and slow. Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument, dated [DATE], showed the following: -He/She was admitted to facility on [DATE]; -His/Her cognition was intact; -He/She had no documented psychosis including delusions and/or hallucinations in the previous seven days; -He/She had no behaviors that affected others in the previous seven days. Review of the resident's care plan, initiated on [DATE], showed no interventions to address the resident's mental health, including mental health services from a therapist, and no documentation of interventions to address the resident's mental status and mood following the recent birth of a son/daughter and then loss of the child to protective custody. Review showed no interventions to address the resident evaluation to transition to a less restrictive environment. During an interview on [DATE] at 6:00 P.M., the resident said the following: -Resident #23 bullied him/her and Resident #24; -Resident #23 called him/her a meth head junky who was not going to get his/her kid back, told him/her he/she was ugly because he/she had no teeth, and he/she was going to beat the fuck out of us; -He/She told staff, including administration and his/her guardian about Resident' #23's comments; -Resident #23 would throw a fist and had chest bumped him/her; -He/She was scared of Resident #23, but he/she could not respond because he/she wanted to get out of the facility and be with his/her child. During an interview on [DATE] at 11:30 A.M., the resident's guardian said the resident had called him/her to report Resident #23 was bullying him/her. The resident was trying to be good and not have any behaviors because he/she wanted to get back to his/her child. During an interview on [DATE] at 9:26 A.M., the administrator said the following: -The facility was working with a state agency, the resident's guardian, and court system for the resident to be able to have visitation with his/her child; (continued on next page)

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	265330	A. Building B. Wing	03/22/2022

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F 0742 Level of Harm - Actual harm Residents Affected - Few	-The resident had not voiced concerns to staff about being depressed. The resident wanted to be good so he/she could get out to be with his/her child; -Staff encouraged the resident to attend groups, medications were administered as ordered, and counseling had been requested. She was unsure if the resident had started counseling sessions or if it was in process. Counseling service required written consents and paper work to be completed prior to initiation of services. She was unsure if that had been completed yet, but a request had been made; -The resident had to become acclimated with his/her new environment and being in a secured unit. The resident learned how to navigate with new surroundings. 2. Review of Resident #24's PASRR, dated [DATE], showed the following: -The resident was raised by his/her grandparents and lived with them most of his/her life. His/Her grandparent, to whom he/she was very close, died in late [DATE]. He/She still had contact with his/her parent; -His/Her diagnoses included paranoid schizophrenia (presence of one or more prominent delusions or auditory hallucinations in a person who have otherwise relatively normal thinking ability and emotions), schizoaffective disorder, social phobia (fear of social situations), dysthymic disorder (mental and behavioral disorder specifically a disorder primarily of mood consisting of same cognitive and physical problems as depression, but with longer lasting symptoms), borderline personality disorder, adjustment disorder (type of mental disorder resulting from maladaptive or unhealthy responses to stressful of psychologically distressing life events), PTSD, anxiety disorder, delirium (a disturbed state of mind), depressive disorder, and substance-induced mood disorder; -His/Her symptoms included mood instability, severely depressed mood, sad demeanor, suicidal ideations by history, feelings of guilt/hopelessness, very high anxiety level, crying spells, frequent worries and fears, self-isolation, low energy level, impulsivity, impaired insight/judgement, marked physiological reactions to internal/external cues that resemble aspects of traumatic events, efforts to avoid memories of events, negative alterations in mood/cognition, persistent negative emotional state including fear, anxiety, guilt, and reckless/self-destructive behaviors; -He/She required 24 hour/daily supervision and oversight to assure he/she was safe and to assure he/she had consistent access to psychotropic medications and psychiatric follow up; -He/She would benefit from a daily structured routine and behavioral program to improve ability to function, care for self, and cope with stressors related to his/her traumatic history and patterns of self-destructive behaviors; -He/She required ongoing medical and psychiatric follow up to promote maximum stability; -He/She would benefit from staff support during periods of severely depressed mood or anxiety to assist him/her to calm self, choose options for managing his/her emotions that were not harmful in nature; (continued on next page)

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	265330	A. Building B. Wing	03/22/2022

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F 0742 Level of Harm - Actual harm Residents Affected - Few	-Notify provider if he/she posed a potential threat to injure self and or others. Review of the resident's care plan showed no documentation of interventions to address the resident's identified needs on his/her PASRR completed on [DATE]. The care plan did not address providing the resident with a structured routine and behavioral program to improve ability to function, care for self, and cope with stressors related to his/her traumatic history and patterns of self-destructive behaviors; did not address staff providing support during periods of severely depressed mood or anxiety to assist him/her to calm self, and to choose options for managing his/her emotions that were not harmful in nature; did not address the World of Focus Program (as identified as a benefit to the resident on the PASRR) to increase understanding of his/her mental health issues, to learn new coping skills, and to develop increased independence in managing his/her emotions and behaviors; did not address providing the resident with a structured environment including provision of individual personal space, maintaining an environment with a minimum of visual/auditory distractions, assessing and planning for level of supervision required to prevent harm to self or others; did not address staff providing assistance to ensure the resident maintained contact with his/her mother if authorized by his/her legal guardian; and did not address staff providing assistance to the resident to engage in social and recreational activities to decrease sense of isolation and loneliness. Review of the resident's annual MDS, dated [DATE], showed the following: -His/Her cognition was intact; -He/She had no evidence of psychosis (hallucinations or delusions) in the previous seven days; -He/She had not had any behaviors in the previous seven days. During an interview on [DATE] at 9:40 A.M., the resident said the following: -He/She was fearful of Resident #23 because he/she bullied him/her; -Resident #23 would say things like, go have a panic attack and die, and cry baby, cry baby, go suck your thumb; -He/She was afraid of Resident #23 and had not been sticking up for himself/herself, but approximately four months ago, he/she had enough and ran down the hall and hit Resident #23; -He/She was not normally a violent person, but he/she couldn't take it anymore; -Staff just tell him/her that he/she just needs to walk away and do nothing else to stop the bullying; -He/She took PRN medication because it was stressful here, there were a lot of fights, yelling, and drama; -Staff attempt to control it, but could not; -There were no activities for residents. (continued on next page)

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	03/22/2022

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 - Actual harm Residents Affected - Few	During an interview on [DATE] at 5:50 P.M., Certified Medication Technician (CMT) K said the following: -The resident would cycle and be depressed and think everyone was against him/her; -When Resident #24 was depressed he/she would call the nurse and administer PRN medication for agitation/depression. 3. Review of Resident #23's PASRR, dated [DATE], showed the following: -Diagnoses included bipolar disorder, intermittent explosive disorder (disorder characterized by recurrent episodes of serious assaultive acts or destruction of property due to failure to resist aggressive impulsiveness), oppositional defiant disorder, attention disorder with hyperactivity (neurodevelopmental disorder characterized by inattention or excessive activity and impulsivity which are otherwise not appropriate for a person's age), schizoaffective disorder, mild intellectual disorder and severe intellectual disorder, obstructive hydrocephalus (accumulation of cerebral spinal fluid within the ventricle of the brain that causes obstruction in any area of the brain) history of a total brain injury, and Rett's syndrome (genetic neurological disorder that affects the way the brain develops); -The resident had history of behaviors, impulsivity, emotional/anger outbursts. He/She had poor boundaries, mood swings, manic episodes, periods of agitation, history of property, and aggression; -He/She had recent admission to psych for homicidal ideation toward his/her guardian and made threats to kill him/her out of anger over the phone. He/She had poor insight and judgement. He/She had a progressive decline over the past six months. He/She had ongoing behaviors and problems since childhood; -He/She required 24-hour supervision due to aggressive behaviors, impulsiveness, emotional outbursts, and poor insight and judgement. Review of the resident's admission MDS, dated [DATE], showed the following: -He/She was admitted to the facility on [DATE]; -His/Her cognition was intact; -He/She had verbal behavioral symptoms toward others one to three days of the previous seven-day look back period; -He/She had other behavioral symptoms not directed toward others such as hitting, scratching self, pacing, and verbal/vocal symptoms like screaming or disruptive sounds; -Overall behavioral symptoms interfered with resident's participation in activities and/or social interaction; -He/She significantly intruded on privacy and activities of others; (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	-He/She significantly disrupted care/living environment. Review of the resident's behavioral progress note, dated [DATE] at 8:34 P.M., showed the resident remained two-on-one (two staff to one resident) monitoring for protective oversight. He/She continued to show increased agitation and displayed difficult-to-redirect behaviors and a threatening manner. Charge nurse conferred with facility administration as well as physician and responsible party. Orders received to send the resident to the hospital for psychiatric evaluation. Facility believed the resident required acute physician and medication evaluation Review of the resident's medical record showed no documentation a care plan was developed at this time to address the resident's behaviors. Review of the resident's behavioral progress note, dated [DATE] at 11:05 A.M., showed staff met with the resident concerning behavior earlier while he/she was in the Hangout (a common area in the facility for residents to socialize and participate in activities). The resident reported that a peer called him/her a bitch, and he/she became upset and swung the door open hard. The door hit a peer, but it was not his/her intention to hit the peer. He/She was just upset and angrily swung it open. The resident was educated on appropriate behaviors and Hangout expectations. The resident verbalized understanding. The resident may return to the Hangout on [DATE]. Review of the resident's behavioral progress note, dated [DATE] at 12:21 P.M., showed the resident was yelling in the hall and was destroying peers' art hanging on the doors. He/She was taken to the administrator's office to discuss positive coping skills and goals. He/She was aggressive and threatening to attack peers when he/she had the chance due to his/her feeling that some peers were favored. The physician ordered as needed (PRN) Ativan (antianxiety medication) injection. Once the resident was able to remain calm, he/she requested to FaceTime (video call via an electronic device) his/her family member once or twice a week to help him/her cope. Staff ensured he/she would be able to do so. He/She was sent back to the hall with zero concerns. Review of the resident's care plan, initiated on [DATE], showed the following: -He/She may attend the Hangout; -On [DATE], the resident was suspended from the Hangout. The resident swung the door and struck peer on the knee. The resident verbalized the action was not on purpose, but peer reported the resident intentionally struck him/her. Review showed no documentation interventions were developed to address the resident's behaviors on [DATE]. Further review showed no documentation of the resident's behaviors on [DATE] and interventions to prevent further incidents, including FaceTime with his/her family member to help him/her cope. Review showed no documentation of a plan to ensure the resident would be able to FaceTime his/her family member twice a week as staff told him/her would be done (per the resident's request). (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	Review of the facility's Registered Nurse Investigation (RNI), dated [DATE], showed Resident #24 and Resident #23 purchased a vape (electronic cigarette) by splitting the cost with the agreement that Resident #23 could hit the vape (inhale the electronic cigarette) anytime he/she wanted to. When Resident #24 became irritated with Resident #23 for coming into his/her room and hitting the vape, he/she asked Resident #23 to back off and give him/her a minute. Resident #23 went in the hallway and words were exchanged between the two residents. Staff began to redirect both residents and told them the situation would be handled and administration would be notified. The residents continued exchanging words and a code green (behavioral emergency) was called to the unit. Resident #24 ran down the hall charging at Resident #23. Staff stepped in front of Resident #23 and stopped Resident #24 from striking Resident #23. While staff focused on keeping Resident #24 from striking Resident #23, Resident #23 went behind the staff and swung and struck Resident #24. Resident #24 fell backwards and hit his/her head on the floor. As additional staff arrived, the residents were separated. Resident #24 was sent to the hospital emergency room for evaluation and treatment related to hitting his/her head. Conclusion of the investigation showed Resident #23 became loud and upset when Resident #24 asked him/her to wait to use their mutual vape. Resident #24 gave Resident #23 the vape, but Resident #23 continued to talk loudly about the situation. Due to Resident #24 initiating the altercation, he/she was placed on one-on-one observation until he/she was sent for a psychiatric evaluation per physician's orders. Review of Resident #23's care plan, updated [DATE], showed the resident could not return to the Hangout until he/she met with the administrator due to borrowing/selling/trading, and a physical altercation with his/her peer (Resident #24). Review showed no interventions, other than suspending the resident from the Hangout (revoking a privilege), were implemented to address the resident's behaviors on [DATE]. Review of Resident #24's care plan showed on [DATE], he/she charged after peer and attempted to attack the peer. While staff were attempting to keep the resident from making contact with peer, peer struck resident which caused resident to lose his/her balance, fall backwards, and strike his/her head on the floor. A code green was called and residents were separated. The resident was sent to hospital for medical evaluation and later sent to another facility for psychiatric evaluation. (Review showed no interventions were added to the care plan to address the resident's behavior). Review of Resident #23's progress notes, dated [DATE] at 8:02 P.M., showed the resident provoked peers on his/her hall throughout the day, causing staff to intervene and redirect multiple times. The charge nurse was on the hall and heard the resident cussing at peers and threatening to drag [NAME] and telling peers to get the fuck down the hall. Charge nurse intervened, situation was deescalated, peers were separated, and the administrator was notified of the resident's behaviors. Review of resident's record showed no documentation staff attempted to identify the root cause of the resident's behavior and implement interventions to address the resident's behavior. Review of the resident's care plan, initiated on [DATE], showed the following: -He/She had manifestations of behaviors related to his/her mental illness that may create disturbances that affect others. Behaviors included talking loudly, being rude to both staff and peers, and exhibiting verbal and physical aggression toward peers; -Desired outcome was to minimize episodes of inappropriate behaviors that could affect others; (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	-On [DATE], a peer became upset when he/she was talking loudly and rude towards staff and peers. While staff were redirecting and educating the resident on appropriate behaviors and unit rules, peer walked in room behind staff and struck resident (date initiated [DATE]); -On [DATE], the resident broke unit rules by purchasing a vape with a peer (Resident #24) to share. He/She became upset when peer didn't honor their agreement. Peer charged at resident while staff were focused on keeping peer from hitting resident. The resident took the opportunity to strike peer. The residents were separated. (date initiated [DATE]); -Interventions added on [DATE] included to administer and monitor medications as ordered, give positive feedback for good behaviors, and pharmacy consultant would review medications monthly and as needed (PRN). Review showed no further interventions documented to address the resident's verbal and physical aggression toward other residents. -The care plan did not direct staff to suspend or revoke use of the Hangout to modify behaviors. Review of the resident's behavioral progress note, dated [DATE] at 6:05 P.M., showed the resident was yelling and threatening peers. Staff attempted to redirect. The resident went in his/her room for a short amount of time, but opened the door and yelled at the charge nurse, why don't you stop worrying about who I'm threatening and get me some fucking juice! The charge nurse educated the resident on appropriate communication with staff without use of curse words and yelling. The resident threatened to slap the charge nurse and a code green was called. Staff were not able to redirect the resident, and staff administered PRN medication to address. Review of the resident's record showed no documentation staff attempted to identify the root cause of the resident's behavior and implement interventions to address the resident's verbal aggression and threats of physical aggression tow [TRUNCATED]

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 32530 Refer to Event ID YST412. Based on interview and record review, the facility failed to ensure Schedule II narcotic pain medication was not left unsecured and unattended. Staff failed to secure one resident's (Resident #40) card (40 tablets) of oxycodone (narcotic pain medication) in a locked compartment and left the medication unattended. The resident's medication was identified as missing from the facility while left unsecured and unattended. The facility census was 176. Review of an email correspondence from the administrator, dated 4/7/22, showed the facility did not have a policy addressing the storage of narcotic medication. 1. Review of Resident #40's admission Minimum Data Set (MDS), a federally mandated assessment instrument to be completed by the facility, dated 10/13/21, showed the following: -Presence of pain rated at five of ten; -Received scheduled and as needed (PRN) pain medication. Review of the resident's care plan, dated 1/13/22, showed the resident had chronic pain and received oxycodone to alleviate his/her pain. Review of the resident's Physician Order Sheet (POS), dated February 2022, showed the following: -Diagnoses included chronic pain and ankylosing spondylitis (arthritis causing lower back pain); -Oxycodone HCL tablet 10 milligrams (mg) every six hours as PRN for pain. Review of the pharmacy requisition document, dated 2/18/22, showed a card containing 40 tablets of oxycodone 10 mg and bearing the name of the resident was delivered to the facility and signed for by Licensed Practical Nurse (LPN) A on 2/19/22 at 12:15 A.M. Review of a progress note authored by the administrator, dated 2/19/22 at 5:00 A.M. as a late entry, showed the charge nurse was stocking the medication cart following delivery from pharmacy and found a 40 count card of oxycodone 10 mg missing. The charge nurse checked the pharmacy manifest and found the narcotic card was listed and signed for by a fell ow charge nurse. The charge nurse searched the medication room, nurse's station, medication delivery tote, etc. The card of medications could not be located. During interview on 4/1/22 at 7:17 A.M., LPN A said the following: -He/She recalled checking in the resident's card of oxycodone 40 tabs with LPN B on 2/19/22; (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Once they separated the medications, LPN B carried the medications to his/her assigned unit; -A couple of hours later, he/she was notified the resident's oxycodone was missing. During interview on 3/9/22 at 12:54 P.M., LPN B said the following: -He/She and LPN A both observed and accepted the resident's card of oxycodone 10 mg, and then LPN A separated the medications to their perspective halls; -He/She carried the medications for his/her halls in a red medication tote to the Meadowbrook nursing station area, and sat the tote on the sink counter. The tote was not locked behind a door; -He/She left the tote there to go and clean a resident's wheelchair. When he/she returned, the tote was sitting on the floor in the charting room where the door was open; -He/She questioned Certified Nurse Assistant (CNA) C as to why he/she moved the tote, and CNA C said he/she moved it because he/she needed to clean the sink; -He/She had been educated that medications should be kept behind a locked door in the medication room or in a locked medication cart and depending on the drug, some behind two locks; -He/She should not have left the medications in an unsecured location. Review of CNA C's written statement, dated 2/19/22, showed he/she was cleaning and bleaching the Meadowbrook unit and nurses station area. A red box/tub was on the sink area he/she needed to clean and was in his/her way so he/she moved it into the nurse's station room. During interview on 4/1/22 at 1:08 P.M., CNA Z said the following: -He/She worked the night of the incident with CNA C. LPN B was the charge nurse; -He/She saw CNA C cleaning around the area where the red tote had been, and then he/she observed CNA C carry the tote to the office; -He/She saw the tote again, sitting on the floor in the nurse's office behind the door. The door to the room was open. During interviews on 3/15/22 at 5:10 P.M. and 4/6/22 at 1:02 P.M., the administrator said the following: -The charge nurses were responsible for checking in medications once they were received from the pharmacy, and should immediately place the medications under lock and key; -She expected schedule II narcotic medications to be locked behind two locks; -She would not expect staff to leave medications unattended. MO00198072