STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175369	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Locust Grove Village	701 W 6th Street LA Crosse, KS 67548

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility identified a census of 34 residents, with three residents reviewed for abuse, neglect, and exploitation. Based on record review, observation, and interview, the facility failed to prevent an episode of staff-to-resident physical abuse. On 06/28/25 at approximately 06:40 PM, Certified Nurse Aide (CNA) M took cognitively impaired Resident (R)1 to the bathroom. CNA M called for assistance, and CNA N came to R1's room. CNA M told CNA N that R1 bit her, so CNA N took over care. CNA N noticed R1 was dabbing her face with toilet paper, and the toilet paper had blood on it. CNA N asked R1 what happened, and R1 said, Honey, can you believe it? Her fist hit my jaw. CNA N observed a purple bruise on R1's right jaw and blood in the resident's mouth. CNA N informed LN G and CNA M of R1's statement. CNA M denied hitting R1. Following the incident, R1 became scared and paranoid to be in her room, afraid she was there, and did not want anyone to touch her. The facility's failure to prevent the staff-to-resident physical abuse placed R1 in immediate jeopardy.Findings included:- R1's Electronic Medical Record (EMR) documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion) without behavioral disturbance, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), hypertension (high blood pressure), and pain.R1's Annual Minimum Data Set, dated 06/20/25, documented R1 had a Brief Interview for Mental Status (BIMS) score of four, which indicated severe cognitive impairment. The MDS documented R1 required supervision with eating, oral hygiene, toilet transfer, and ambulation. The MDS documented R1 was dependent on staff for bathing and required moderate to extensive assistance with toileting, dressing, personal hygiene, and sitting to lying. The MDS documented R1 had no physical behaviors directed towards others during the lookback period; R1 had verbal behaviors one to three days during the lookback period.The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 06/20/25, documented R1 had severe cognitive impairment due to dementia with behaviors. R1's behaviors included verbal behavior towards others and wandering. R1's communication ability was impacted by cognitive impairment and hearing problems. R1 required staff assistance with activities of daily living.The Behavioral Symptoms CAA, dated 06/20/25, documented R1 had wandering and verbal behaviors directed towards others one day during the lookback period. R1's behaviors did not interfere with other residents or place R1 at risk. R1's behaviors were easily redirectable by giving foods and fluids.The Psychosocial Well-Being CAA, dated 06/20/25, documented R1 had insomnia, mood swings, restlessness, agitation, and anxiety. R1's anxiety was due to her dementia and limited ability to comprehend and cope. The CAA noted observation of R1's non-verbal communication was important, as R1 conveyed her moods by facial expressions and body language. R1 liked to be around others, talk, and hold hands with staff and other residents.R1's Care Plan directed staff R1 needed guidance, cues, and assistance with activities of daily living, and to allow R1 to do what she could (01/06/25). The care plan directed staff if R1 seemed anxious to help R1 to an area with less noise and activity (03/28/25).R1's Care Plan documented interventions that directed staff R1 had dementia, and to allow her to make choices and decisions as much as R1 was able; R1 liked to spend time in the living areas visiting and talking to other residents and staff (06/20/25). The Care Plan lacked interventions related to behaviors prior to the incident on 06/28/25.The Weekly Skin Assessment on 06/16/25, documented R1's skin was warm and dry, with no skin issues noted. The Progress Note, dated 06/28/25 at 07:30 PM, documented R1 stated she had to go to the bathroom, and staff attempted to take her. R1 became agitated and started swinging and hitting at the staff. After the incident, R1 had a small bruise to her chin and scratches to her cheek. Staff applied an ice pack to the resident's chin. The note recorded staff notified Administrative Nurse D and planned to notify R1's physician. The Progress Note, dated 06/28/25 at 09:13 PM, documented staff notified R1's responsible party of the incident, and LN G explained R1 was combative during toileting and R1 had a bruise on her chin. R1's responsible party was understanding and stated the resident could get that way sometimes.The Progress Note, dated 06/28/25 at 11:36 PM, documented the bruising on R1's chin was purple in color and more prominent. R1 was agitated and wanted out of bed. Staff assisted R1 to the toilet, then to her wheelchair, and gave her fluids. R1 left the ice pack on her chin for about twenty minutes.Licensed Nurse (LN) G's Notarized Witness Statement, dated 06/28/25, documented at approximately 06:45 PM, CNA M approached LN G and reported R1 bit her neck. LN G noted CNA M's neck was red on the left side, but there were no bite marks. LN G documented CNA N said CNA M hit R1. CNA N then showed LN G pictures of R1. CNA M stated her hands were down and she did not hit R1. LN G noted she asked CNA M to leave. After CNA M