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	09/11/2024

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27168 The facility had a census of 36 residents. The sample included 13 residents, with one reviewed for side rails. Based on observation, record review, and interview, the facility failed to ensure a bed rail that met safety requirements and addressed risks for entrapment for Resident (R)4. This placed her at risk for accident or injury due to unidentified risks associated with side rail use. Findings included: - R4's Electronic Medical Record (EMR) recorded diagnoses of Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, spinal stenosis (degenerative condition of the spine that could cause weakness and loss of use of extremities), and right knee pain. R4's Admission Minimum Data Set (MDS), dated [DATE], recorded the resident had a Brief Interview for Mental Status (BIMS) score of 12 indicating mild cognitive impairment. The MDS documented R4 required the assistance of one staff with bed mobility and transfers. The MDS lacked documentation the resident had side rails. R4's EMR recorded a Side Rail Assessment completed on 07/10/24 upon admission. The assessment documented the resident does not transfer independently and the rails were not a high risk for entrapment. The rails and hoops were considered for safety and security, and the resident would need to use the side rail due to her weakness and balance deficit; the rail would help the resident turn side to side, move up and down in bed, pull herself from a laying to sitting position, supporting herself, transferring more safely, exiting the bed more safely, and improving balance. The assessment documented the rails/hoops were recommended due to a family request. Further evaluation was required by physical therapy or occupational therapy to recommend the type of side rail and usage. The assessment did not document the rail's openings or address the space between the side rail/hoop and the mattress. R4's EMR lacked evidence that therapy evaluated the type of rail and its usage. (continued on next page)

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

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Logbook Documentation provided by the facility revealed the facility's maintenance staff checked the bed and rails on 08/07/24 for cleaning and care, sanitizing methods, environmental conditions for storage and transport as well as a Maintenance Check. The document recorded the Maintenance Check which included inspecting connectors on rails and tightening as necessary; removal of burs or rough edges to prevent injury; verification of the function of the spring knob assembly if applicable and ensuring the latch was free of dirt and/or foreign material that could impair function; ensuring the side rails engaged and locked as specified; tightening, adjusting, or replacing any parts such as end caps, knobs, bolts, screws etc. that were loose or showed signs of wear, or were missing. The check did not address the rail opening, or the area between the rail and mattress. On 09/10/24 at 04:00 PM, observation revealed a one-fourth side rail on the left side of R4's bed with an opening approximately 16.5 inches by 32 inches. Continued observation and examination revealed the side rail was able to slip out of the bed and move. The resident had her own personal full-size mattress and used a remote control to elevate the head of the bed and change the bed position at the foot of the mattress. On 09/11/2024 at 10:00 AM, Administrative Nurse E verified the bed rails on R4's bed had too large of an opening, and the rail was not able to be affixed to the bed securely for stability and was able to be moved easily. Administrative Nurse A verified the facility lacked any further assessment for the use of the side rail. The Bed Safety policy, dated 2014, documented the facility strives to provide a safe sleeping environment for the resident. The resident's sleeping environment would be assessed by the interdisciplinary team, to consider the resident's safety, medical conditions, comfort, and freedom of movement, as well as input from the resident and family regarding previous sleeping habits and bed environment. To try to prevent deaths/injuries from the beds and related equipment (including frame, mattress, side rails, headboard, footboard, and bed accessories), the facility shall promote the following approaches: Inspection by the maintenance staff of all beds and related equipment as part of our regular bed safety program to identify risks and problems including potential entrapment risks. Review that gaps within the bed system are within the dimensions established by the Federal Drug Administration (FDA) The review shall consider situations that could be caused by the resident's weight, movement, or bed position. Ensure that the bed rails are properly installed using the manufacturer's instructions or other pertinent safety guidance to ensure proper fit. Identify additional safety measures for residents who have been identified as having a higher than usual risk for injury including entrapment such as altered mental status, or restlessness. Maintenance will document this review in the TELS program. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's education and training activities would include instruction about risk factors for resident injury due to beds, and strategies for reducing risk factors for injury, including entrapment. If side rails were used, there would be an interdisciplinary assessment of the resident, consultation with the Attending Physician, and input from the resident and/or legal representative. The staff would obtain consent for the use of the side rails from the resident or the resident's legal guardian. Before using the side rails for any reason, the staff shall inform the resident and family about the benefits and potential hazards associated with the side rails. The facility failed to adequately assess R4's actual rail in use to ensure safe openings and failed to assess for safe use of a side rail prior to placing it on R4's bed. This placed her at risk for accident or injury due to unidentified risks associated with side rail use.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27168 The facility had a census of 36 residents. The sample included 13 residents, with five reviewed for unnecessary medications. Based on observation, interview, and record review, the facility failed to ensure the Consultant Pharmacist (CP) identified and reported the lack of a 14-day stop date or specified duration, for Resident (R)10's as needed (PRN) antianxiety (class of medications that calm and relax people) medication. This placed R10 at risk for unintended effects related to psychotropic drug medications. Findings include: - R10's Electronic Health Record (EHR) revealed diagnoses of dementia (a progressive mental disorder characterized by failing memory, and confusion), major depressive disorder (major mood disorder that causes persistent feelings of sadness), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). R10's Quarterly Minimum Data Set (MDS), dated [DATE], recorded R10 had severely impaired cognition. The MDS recorded he required extensive assistance from two staff with bed mobility and transfers. The MDS lacked documentation R10 received an antianxiety medication during the observation period. R10's Care Plan, dated 07/25/24, recorded R10 required extensive assistance with most activities of daily living (ADL) care. R10's Care Plan documented the resident received lorazepam (antianxiety medication) for anxiety and restlessness. R10's Physician's Order, dated 07/25/24, directed the staff to administer lorazepam 0.5 milligrams (mg) to 3 mg, three times a day (morning, afternoon, and at bedtime) PRN. The order lacked a stop date. R10's EHR lacked evidence of a specified duration which included a physician's rationale for the extended use of the PRN lorazepam. The Consultant Pharmacist's monthly review for R10 completed on 08/19/24 lacked evidence the CP identified the PRN lorazepam with no stop date. On 09/10/24 at 07:45 AM, R10 sat in a wheelchair at the dining room table. Certified Medication Aide (CMA) R administered the resident's medication. On 09/11/24 at 11:00 AM, Administrative Nurse D verified the resident received lorazepam PRN, with a physician order date of 07/25/24, and no stop date. Administrative Nurse D verified the Consultant Pharmacist had sent monthly reviews to the facility and lacked a recommendation for the 14-day stop date or rationale for continued use of the medication. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Pharmacy Services- Role of the Consulting Pharmacist policy, dated March 2023 documented the facility would contract the services of the Consulting Pharmacist. The Consulting Pharmacist shall provide consultation on all aspects of pharmacy services in the facility, including identifying pertinent resources and references about medications and their proper use and monitoring in the population. The Consultant Pharmacist would review the medication regimen of each resident at least monthly, or more frequently under certain conditions, based on applicable federal and state guidelines. Appropriate communication of information to prescribers and facility leadership about potential or actual problems related to any aspect of medications and pharmacy services, including medication irregularities, pertinent resident-specific documentation irregularities, and pertinent resident-specific documentation in the medical record, as indicated. The facility failed to ensure the CP identified and reported the lack of a 14-day stop date for the use of PRN lorazepam for R10. This placed the resident at risk for unnecessary psychotropic medication.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27168 The facility had a census of 36 residents. The sample included 13 residents, with five reviewed for unnecessary medications. Based on observations, interviews, and record review, the facility failed to ensure a 14-day stop date or a specified duration with rationale for Resident (R)10's ongoing as-needed (PRN) antianxiety (class of medications that calm and relax people) medication. This placed R10 at risk for unintended effects related to psychotropic (alters mood or thought) drug medications. Findings include: - R10's Electronic Health Record (EHR) revealed diagnoses of dementia (a progressive mental disorder characterized by failing memory, and confusion), major depressive disorder (major mood disorder that causes persistent feelings of sadness), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). R10's Quarterly Minimum Data Set (MDS), dated [DATE], recorded R10 had severely impaired cognition. The MDS recorded he required extensive assistance from two staff with bed mobility and transfers. The MDS lacked documentation R10 received an antianxiety medication during the observation period. R10's Care Plan, dated 07/25/24, recorded R10 required extensive assistance with most activities of daily living (ADL) care. R10's Care Plan documented the resident received lorazepam (antianxiety medication) for anxiety and restlessness. R10's Physician's Order, dated 07/25/24, directed the staff to administer lorazepam 0.5 milligrams (mg) to 3 mg, three times a day (morning, afternoon, and at bedtime) PRN. The order lacked a stop date. R10's EMR lacked evidence of a specified duration which included a physician's rationale for the extended use of the PRN lorazepam. On 09/10/24 at 07:45 AM, R10 sat in a wheelchair at the dining room table. Certified Medication Aide (CMA) R administered the resident's medication. On 09/11/24 at 11:00 PM, Administrative Nurse D verified the resident received lorazepam PRN, with a physician order date of 7/25/24. Administrative Nurse D verified the order did not have a 14-day stop date or a reason for the continued use with the appropriate rationale. The facility did not provide a policy related to PRN psychotropic medications. The facility failed to ensure R10 was free of unnecessary psychotropic drugs when they failed to obtain a stop date for the use of PRN lorazepam. This placed R10 at risk for adverse side effects from the continued use of psychotropic medications.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 26768 The facility had a census of 36 residents. Based on observation, interview, and record review the facility failed to store biologicals as required when staff failed to discard or destroy expired medications and vaccines. This deficient practice placed residents of the facility at risk of receiving ineffective medications. Findings included: - On 09/09/24 at 09:33 AM, observation revealed Certified Medication Aide (CMA) M obtained medication to administer to residents from the Shade medication cart. The cart contained one bottle of multivitamins with minerals which had no expiration date. On 09/09/24 at 09:40 AM, Licensed Nurse (LN) G opened the medication storage room, and observation in the medication refrigerator revealed three bisacodyl (laxative) suppositories that expired 07/2024; three bisacodyl suppositories that expired 05/2024; three boxes of Fluzone quadrivalent vaccines (flu shot), expired 06/2024 and two boxes of Fluzone high dose vaccines, expired 06/2024. LNG verified the expiration dates. On 09/09/24 at 11:00 AM, Administrative Nurse D verified staff were to remove from stock or dispose of expired medications. The facility's Storage of Medications policy, dated 04/2014, stated drug containers that had missing, incomplete, or incorrect labels should be returned to the pharmacy for proper labeling. The policy stated the facility should not use discontinued or outdated drugs or biologicals and all such drugs would be returned to the dispensing pharmacy or destroyed. The facility failed to discard or destroy expired medications and vaccines, placing residents of the facility at risk of receiving ineffective medications.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 26768 The facility had a census of 36 residents. The sample included 13 residents. Based on observation, interview, and record review the facility failed to employ a full time Certified Dietary Manager (CDM) to supervise the preparation of meals and sanitation in the facility's kitchen. This deficient practice placed the 36 residents of the facility at risk for inadequate nutrition. Findings included: - On 09/10/24 at 12:00 PM, observation revealed Dietary Staff (DS) BB in the facility kitchen assisting with the noon meal service. On 09/10/24 at 12:45 PM, Dietary Staff (DS) BB stated the prior Registered Dietician (RD) had assisted her with training related to the CDM certification. She stated she had completed the courses and was scheduled to take the test in November 2024. The facility's Dietary Manager policy stated the dietary manager was a certified dietary manager licensed by this state in accordance with the American Dietetic Association rules, regulations and guidelines. The policy stated the dietary manager was responsible for the day-to-day functions of the dietary department. The policy stated during the completion of the CDM course, the RD would provide on-site visits weekly. The facility failed to employ a full time CDM to supervise the preparation of meals and sanitation in the facility's kitchen, placing the 36 residents of the facility at risk for inadequate nutrition.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 26768 The facility had a census of 36 residents. The sample included 13 residents. Based on observation, interview, and record review the facility failed to provide food prepared by methods that conserve nutritive value, flavor, and appearance when dietary staff failed to measure and provide the proper amounts of food for the four residents with a pureed diet. This placed the four residents at risk for impaired nutrition. Findings included: - On 09/10/24 at 11:20 AM, observation revealed Dietary Staff (DS) CC prepared the pureed foods for four residents. DS CC placed several ladles of meatloaf into the mixer without measuring the amount. DS CC then added approximately one-half cup of juice from the pan of vegetables before pureeing the mixture. She did not measure the pureed meatloaf when placing it in a cup for each resident. DS CC then pureed two cups of scalloped potatoes with one-half cup of vegetable juice and did not measure the servings when placed in resident cups. DS CC pureed one cup of squash with a fourth cup of vegetable juice and did not measure the serving size for each resident. On 09/10/24 at 11:20 AM, DS CC stated she did not have recipes for the pureed foods and stated she just eyeballed the amounts instead of measuring. On 09/10/24 at 12:45 PM, Dietary Staff (DS) BB stated should follow recipes for pureed foods and measure portions when serving pureed. She stated the Registered Dietician taught them to measure food before the pureed process. The facility's Standardized Recipes policies, dated 11/2023, stated a file of tested , standardized recipes, adjusted to appropriate yield, was used in the preparation of foods. The recipe file was maintained in the kitchen and was available to cooks throughout their tour of duty. Recipes are periodically reviewed for revisions and updating. The facility's Recommendations for Preparing Pureed Foods directed staff to place one serving of food per serving in the food processor and puree the food item until it is as smooth as possible. If it is too thin add food thickener a little at a time until consistency is reached. When serving pureed food, the quantities may be more or less than the original volume you started with so you may not need to give them all of it. The suggested liquids to use when pureeing foods directed staff to use a broth for meats and vegetable juice milk, or a broth for other foods. The facility failed to provide food prepared by methods that conserve nutritive value, flavor, and appearance while preparing the pureed diet. This placed the affected residents at risk for impaired nutrition.