

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175369	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2026
NAME OF PROVIDER OR SUPPLIER Locust Grove Village		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on observation, record review, and interview, the facility failed to provide Registered Nurse (RN) coverage for eight consecutive hours a day, seven days a week. Findings included:- The facility's August 2025, September 2025, October 2025, November 2025, December 2025, January 2026, and March 2026 nursing schedule lacked evidence of Registered Nurse coverage for eight consecutive hours a day, on the following dates: 08/04/2025, 08/10/2025, 09/27/2025, 10/04/2025, 10/11/2025, 10/18/2025, 10/19/2025, 10/25/2025, 10/26/2025, 11/08/2025, 11/29/2025, 12/19/2025, 12/28/2025, 01/01/2026, 01/03/2026, 01/24/2026, and 03/08/2026. The facility was unable to provide verifiable, auditable evidence of RN coverage. On 07/23/2026 at 10:29 AM, Administrative Nurse D stated the facility did not have a nurse for the days that showed no Registered Nurse (RN) coverage on the Payroll Based Journal (PBJ). Administrative Nurse D stated there was not an RN in the facility on those dates but stated that she was always on call. On 07/22/2026 at 08:39AM Administrative Staff A stated he expected the facility to have an RN in the building for eight hours a day. He stated the facility had talked about applying for a nursing waiver. Administrative Staff A stated the facility used contract nursing when they could. The facility's Nursing Staff policy dated 03/15/2015 documented the facility would have sufficient nursing staff with the appropriate competencies and skill sets to provide nursing and related services. Staffing levels would assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. Staff levels at the facility would consider the number, acuity, and diagnoses of the resident population.		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 175369	Facility ID: 175369 If continuation sheet Page 1 of 10

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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. Based on interviews and record review, the facility failed to provide the services of a full-time certified dietary manager for the 36 residents who resided in the facility and received their meals from the kitchen. Findings included:- On 07/20/2026 at 07:50 AM, Dietary Staff CC stated the facility did not have a Certified Dietary Manager (CDM). She stated she was the kitchen supervisor, and the person taking over the CDM was on vacation. Dietary Staff CC stated Dietary Staff BB had just started taking her classes for the CDM. On 07/22/2026 at 08:00 AM, Administrative Staff A stated he was aware the facility did not have a CDM. He stated the facility did have a person who was taking the class. Administrative Nurse A stated the Registered Dietician comes to the facility once a month. The facility's Dietary Manager policy dated 2018 documented that the day-to-day functions of the dietary department are under the supervision of a qualified dietary manager.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review and interviews, the facility failed to follow sanitary dietary standards related to food storage and service. Findings included:- During the initial tour on 07/20/2026 at 07:40 AM, observation revealed the following: In the walk-in refrigerator, 17 individual pieces of cake and individual slices of pie sat on a stainless-steel cart, wrapped and undated. A steam table pan of beef tips was covered with aluminum foil, unlabeled and undated. A large steam table pan of rice was covered with aluminum foil, unlabeled and undated. A platter of ham slices was placed on the second shelf in the walk-in cooler, unlabeled and undated. A fourth of a jug of apple juice and half a jug of orange juice were on the top shelf of the walk-in refrigerator, unlabeled and undated. In the nutrition area outside the kitchen, three frosted cinnamon rolls were in a snack cart, unlabeled and undated. Outside the dining room area, a white refrigerator contained two buns, a bucket of ice cream, and an open drink that was unlabeled and undated. On 07/21/2026 at 11:00AM the food temperature log revealed no temperatures recorded for 07/04/2026, 07/05/2026, 07/09/2026, 07/10/2026, 07/12/2026, 07/16/2026, 07/17/2026, and 07/19/2026 supper meal. On 07/20/2026, Dietary Staff CC stated the cakes and pies were going to be thrown away. She stated she was unaware that food put in the cooler for the same day needed to be dated and labeled. Dietary Staff CC stated the beef tips and the rice were for supper. She stated the facility had high school kids working in the evening, and food was cooked in the morning for the supper meal. She stated the ham was supposed to be labeled and dated and placed in the freezer, and she was unaware that opened juice jugs needed to have a date. She stated the employee refrigerator used to be cleaned and ensured that no foods were undated or unlabeled; she was unsure if that was still the kitchen staff's duty. On 07/21/2026, Dietary Staff DD stated she was aware the evening shift was not recording temperatures of foods and that there had been complaints the supper meal foods were cold. She stated it was the expectation of the facility to take temperatures before each meal was served. On 07/22/2026 at 08:00AM Administrative Staff A stated he was aware the facility did not have a CDM. He stated the facility did have a person who was taking the class. Administrative Nurse A stated the Registered Dietician comes to the facility once a month. The facility's Food Storage policy dated 06/2014 documented that food storage areas would be maintained in a clean, safe, and sanitary manner.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to store medications and biologicals within professional standards of practice when the facility failed to date check vials of of intramuscular (IM-injected directly into a muscle) lorazepam (a class of medications that calm and relax people), high dose influenza (highly contagious viral infection) vaccine, and influenza vaccine, that were past the date to be used. Findings included:- On [DATE] at 01:50 PM, the medication room refrigerator contained four vials of IM lorazepam, 20 vials of high-dose influenza, and 40 vials of influenza vaccine. The vials were dated 06/2026 and were outside the recommended date to be used. On [DATE] at 1:52 PM, Licensed Nurse (LN) G stated the pharmacist comes once a month and destroys medication and removes all outdated medication. She stated nurses were to periodically check for outdated medication also. On [DATE] at 09:06 AM, Administrative Nurse D stated the pharmacy consultant was at the facility every quarter to destroy medication. She stated she did know the influenza vaccines were outdated and was waiting on a return label to send the vaccine back to get credit. Administrative Nurse D stated she was unaware the lorazepam had expired. She stated it was the overnight shift duty to check the refrigerator for expired medication when taking the temperature of the refrigerator. The facility was unable to provide a policy related to medication storage as requested on [DATE].		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interviews, observation, and record review the facility failed to ensure the as needed (PRN) Benadryl being used for its psychotropic (alters mood or thought) properties had a 14-day stop date or a specified duration with supporting physician documentation for Resident (R) 6's PRN Benadryl. Findings included:- R6's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), insomnia (inability to sleep), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), atrial fibrillation (rapid, irregular heartbeat), hypertension (HTN-elevated blood pressure), and urinary retention (lack of ability to urinate and empty the bladder). The Significant Change Minimum Data Set (MDS) dated 06/16/2026 documented a Brief Interview of Mental Status (BIMS) score of three, which indicated severely impaired cognition. The MDS documented R6 received diuretic (a medication to promote the formation and excretion of urine) medication during the observation. R6's Cognitive Loss/Dementia Care Area Assessment (CAA), dated 06/19/2026, documented he had advanced dementia and periods of confusion. R6's Care Plan documented the following interventions: 06/17/2026 - Staff would administer as needed medication for insomnia. R6 does not sleep well at night. Staff would, as much as possible, minimize daytime sleeping by inviting and encouraging participation in group or individual activities. 06/19/2026 - Staff would provide non-medication approaches to help R6 rest, such as a back rub, quiet atmosphere, consistent schedule, and offer hot chocolate. R6's EMR under the Orders tab revealed the following physician orders: Benadryl (diphenhydramine hcl) (antihistamine) 25 milligram (mg) give one capsule by mouth every four hours as needed for insomnia dated 06/17/2026. The medication order lacked a stop date. On 07/21/2026 at 12:46 PM, R6 pushed himself from the dining room to the common area. R6 locked the brakes on his wheelchair prior to transferring himself into another chair in the common area. Staff refilled R6's insulated cup with water and placed it next to him on the table. On 07/22/2026 at 10:15 AM, Licensed Nurse (LN) H stated R6's Benadryl order should have an automatic stop date after 14 days if used for insomnia. On 07/22/2026 at 10:35 AM, Administrative Nurse D stated R6's Benadryl should have a 14-day stop date if used for insomnia. Administrative Nurse D stated the pharmacist should have caught that during their monthly pharmacy reviews. The facility's undated Psychotropic Medications policy documented the facility residents would not be given any psychotropic medications that are not adequately clinically indicated and necessary to treat a specific condition. Psychotropic medications would be used as clinically indicated and not for convenience. Proper processes would be followed to ensure the medication used was appropriate and not considered a chemical restraint.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on interviews, observation, and record review the facility failed to ensure Resident (R) 6 had a current physician order with an appropriate indication for the ongoing use of an indwelling catheter (a tube inserted into the bladder to drain urine into a collection bag) which included the size of catheter needed. Findings included:- R6's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), insomnia (inability to sleep), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), atrial fibrillation (rapid, irregular heartbeat), hypertension (HTN-elevated blood pressure), and urinary retention (lack of ability to urinate and empty the bladder). The Significant Change Minimum Data Set (MDS) dated 06/16/2026 documented a Brief Interview of Mental Status (BIMS) score of three, which indicated severely impaired cognition. The MDS documented R6 had an indwelling Foley catheter during the observation period. R6's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 06/19/2026 documented he had a Foley catheter in place before admission to hospice for urinary retention. R6's Care Plan documented the following interventions: 11/25/2025 - Staff would provide catheter care every shift. 11/25/2025 - Staff would hand him his shirt and have him put it on. Because of catheter tubing, he required maximum assistance with his pants, and then he was able to assist with pulling his pants on. Staff would help him get his socks and shoes on and off. 12/08/2025 - Staff would irrigate his catheter as needed. 03/25/2026 - Staff would utilize enhanced barrier precautions related to his catheter. 06/17/2026 - Staff would ensure his catheter tubing did not cause pressure to his skin. Staff would continue to utilize his foley catheter (a tube inserted into the bladder to drain urine into a collection bag) and provide catheter care along with peri care every shift and as needed. 07/14/2026 - Staff would change his catheter as needed related to obstructed flow if irrigation was not successful. 18French(Fr)/10 18Fr/10 cubic centimeter (cc). R6's EMR under the Orders tab revealed the following physician orders: Catheter care every shift, twice a day dated 10/31/2025. May irrigate Foley catheter as needed dated 12/07/2025. The EMR lacked a physician order with appropriate indication and size for insertion. On 07/21/2026 at 12:46 PM, R6 pushed himself from the dining room to the common area. R6 locked the brakes on his wheelchair prior to transferring himself into another chair in the common area. Staff refilled R6's insulated cup with water and placed it next to him on the table. On 07/22/2026 at 10:15 AM, Licensed Nurse (LN) H stated the orders for R6's catheter should be under his physician orders in the EMR. LN H was unable to locate R6's catheter orders in his EMR. LN H was not sure what the indication for R6's catheter was or what type and size of catheter was ordered for him. On 07/22/2026 at 10:35 AM, Administrative Nurse D stated the orders for R6's catheter were under the physician orders. Upon review of his orders, she was unable to locate the orders under the physician orders. She stated the orders might be located on the hospice care plan that was scanned into his EMR under the History and Physical tab. She was unable to locate the physician order. She stated R6's catheter was never to be changed again, and he had the catheter for comfort measures. The facility was unable to provide policy-related catheter orders as requested on 07/22/2026.		

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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. Based on interviews, observation, and record review, the facility failed to ensure the Consultant Pharmacist (CP) identified and reported irregularities for Resident(R)6's as needed psychotropic (alters mood or thought) medication. Findings included:- R6's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), insomnia (inability to sleep), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), atrial fibrillation (rapid, irregular heartbeat), hypertension (HTN-elevated blood pressure), and urinary retention (lack of ability to urinate and empty the bladder).The Significant Change Minimum Data Set (MDS) dated 06/16/2026 documented a Brief Interview of Mental Status (BIMS) score of three, which indicated severely impaired cognition. The MDS documented R6 received diuretic (a medication to promote the formation and excretion of urine) medication during the observation.R6's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 06/19/2026 documented he had advanced dementia and periods of confusion. R6 had difficulty sleeping at night.R6's Care Plan, documented the following interventions:06/17/2026 - Staff would administer as needed medication for insomnia. Staff would, as much as possible, minimize daytime sleeping by inviting and encouraging participation in group or individual activities.06/19/2026 - Staff would provide non-medication approaches to help R6 rest, such as a back rub, quiet atmosphere, consistent schedule, and offer hot chocolate.R6's EMR under the Orders tab revealed the following physician orders:Benadryl (diphenhydramine hcl) (antihistamine) 25 milligram (mg) give one capsule by mouth every four hours as needed for insomnia dated 06/17/2026. The medication order lacked a stop date.Review of the Monthly Medication Review (MMR) from October 2025 to July 2026 provided by the facility lacked documentation of a recommendation for an automatic stop date for R6's Benadryl, which was being used for insomnia.On 07/21/2026 at 12:46 PM, R6 pushed himself from the dining room to the common area. R6 locked the brakes on his wheelchair prior to transferring himself into another chair in the common area. Staff refilled R6's insulated cup with water and placed it next to him on the table.On 07/22/2026 at 10:15 AM, Licensed Nurse (LN) H stated she did not address the monthly pharmacy reviews that would be LN G or Administrative Nurse D.On 07/22/2026 at 10:35 AM, Administrative Nurse D stated R6's Benadryl should have a 14-day stop date if used for insomnia. Administrative Nurse D stated she expected the pharmacist would have caught that during their monthly pharmacy reviews.The facility's Medication Regime Reviews policy dated 11/2016 documented the consultant licensed pharmacist would review the drug regimen of each resident at admission, and at least monthly thereafter. The drug review would include a review of the residents' health record.		

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. Based on interviews, observation, and record review, the facility failed to ensure collaboration with the hospice provider for Resident (R) 6. Findings included:- R6's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), insomnia (inability to sleep), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), atrial fibrillation (rapid, irregular heartbeat), hypertension (HTN-elevated blood pressure), and urinary retention (lack of ability to urinate and empty the bladder). The Significant Change Minimum Data Set (MDS) dated 06/16/2026 documented a Brief Interview of Mental Status (BIMS) score of three, which indicated severely impaired cognition. The MDS documented R6 received hospice services during the observation period. R6's Cognitive Loss/Dementia Care Area Assessment (CAA), dated 06/19/2026, documented he had advanced dementia and periods of confusion. R6's Care Plan, documented the following interventions: 06/12/2026 - Staff would report skin breakdown. Staff would follow hospice orders as needed for wound care. Staff would use protective sacral (large triangular bone/area between the two hip bones) dressing and protective paste to inner buttocks as needed. Staff would administer lorazepam (anxiety) as needed for anxiety. Staff would assist with position changes as needed depending on his strength and condition. R6 would use positioning devices and pillows if he became too weak to maintain his own position. Staff would continue his restorative program, as he can tolerate, to maintain joint range of motion (ROM- the full movement potential of a joint, usually its range of flexion and extension) to prevent contractures. Staff would ensure he had access to fluids in and out of his room. Staff would ensure he received oral care each shift. Staff would use softer mouth swabs if a toothbrush became too uncomfortable. Staff would respect his wishes if he refused meals. Staff would initiate hospice standing orders as needed depending on his condition. No labs, x-ray, or provider appointments except his physician. Staff would obtain monthly weights. 06/17/2026 - Staff would administer medication at night as ordered for insomnia. Staff would, as much as possible, minimize daytime sleeping by inviting and encouraging participation in group or individual activities. Staff would administer oxygen as needed. Staff would provide medications as needed for excess secretions and/or anxiety related to air hunger. Staff would provide a regular diet as tolerated and request food or fluid consistency changes as needed for swallowing or chewing problems. Staff would continue to utilize his foley catheter (a tube inserted into the bladder to drain urine into a collection bag) and provide catheter care along with peri care every shift and as needed. Staff would change the catheter as needed. Staff would observe for verbal and nonverbal signs of pain and administer pain medications as ordered. Staff would provide non-medication approaches to manage pain: heat, ice, massage, relaxation, prayer, or meditation. Staff would promote optimal bowel function and record bowel frequency. Staff would provide bowel management as needed. Staff would provide emotional support and understanding to R6 and my family. Staff would acknowledge, validate, and empathize during emotional expressions. 06/19/2026 - Staff would continue to administer medications for atrial fibrillation and HTN. 06/23/2026 - Staff would administer medications as ordered. 07/14/2026 - Staff would keep family informed of any condition changes. Hold pills if unable to safely swallow. Edited: 06/17/2026 The care plan lacked other services provided by hospice and the hospice provider. R6's EMR under the Orders tab revealed the following physician orders: 06/10/2026 Admit to hospice services. On 07/21/2026 at 12:46 PM, R6 pushed himself from the dining room to the common area. R6 locked the brakes on his wheelchair prior to transferring himself into another chair in the common (continued on next page)		

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	area. Staff refilled R6's insulated cup with water and placed it next to him on the table. On 07/22/2026 at 10:05 AM, Certified Nurse Aide (CNA) M stated all staff had access to the resident's care plans. CNA M stated she had a care plan sheet that contained the residents care plan information. CNA M stated she was unable to tell if R6 was on hospice services. CNA M stated the nurse would let the staff know if a resident was on hospice. On 07/22/2026 at 10:15 AM, Licensed Nurse (LN) H stated she thought the hospice staff would come weekly. LN H said she was not aware that hospice provided any written communication at the time of their visits to R6. LN H was unable to find any written documentation from R6's hospice provider. On 07/22/2026 at 10:35 AM, Administrative Nurse D stated the facility staff would know which hospice provided services to R6 because the facility only contracted with one hospice. Administrative Nurse D stated that hospice did not provide extra bathing services, but did receive a weekly visit from a nurse and social service staff. The facility's Hospice Program policy dated 01/2018 documented that the facility contracts for hospice services for residents who wish to participate in such programs.		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on record reviews, and interviews, the facility failed to offer and provide or obtain a signed declination for the Pneumococcal Conjugate Vaccine (PCV20- vaccination for bacterial pneumonia infections) for Resident (R)11, R4 and R25. Findings included:- Review of R11's clinical record revealed R11 received the PCV-13 on 03/07/2019, and the PPV23 on 01/20/2021. R11's medical record lacked a declination for the PCV20, or evidence that the PCV20 was offered and administered. R4's clinical record lacked a declination for the PCV20, or evidence the PCV20 vaccine was offered and administered. R25's clinical record lacked a declination for PCV20, or evidence the PCV20 vaccine was offered and administered. On 07/21/2026 at 02:10 PM, Administrative Nurse D stated immunizations were tracked by the Minimum Data Set (MDS) coordinator. She stated she does not get a signed declination for the PCV20. Administrative Nurse D stated she placed a note in the quarterly MDS progress note that the resident had declined the PCV20. She stated R11 had not received his vaccine due to his wife not wanting him to leave the facility. Administrative Nurse D stated the residents had to leave the facility to receive the vaccines. The facility's Pneumococcal Vaccine policy dated 11/2023 documented that receipt of the vaccinations was essential to the health and well-being of the facility's residents. The facility would have an established immunization program against pneumococcal disease. All residents would be offered the pneumococcal vaccine to aid in preventing infections and pneumonia.		