STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(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	STREET ADDRESS, CITY, STATE, ZIP CODE
LOCUST GROVE VILLAGE	**701 W 6TH STREET , LA CROSSE, Kansas, 67548**

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F0000	INITIAL COMMENTS The following citations represent the findings of a Health Recertification Survey and complaint survey regarding allegations in 3055879 and 2705185. The census was 36. The sample included 12 residents.	F0000		
F0727 SS = F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): §483.35(b)(1)-(3) §483.35(b) Registered Nurse §483.35(b)(1)Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is NOT MET as evidenced by: 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,	F0727		

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0727 SS = F	Continued from page 1 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.	F0727		
F0801 SS = F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a	F0801		

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F0801 SS = F	Continued from page 2 regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures,	F0801		

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F0801 SS = F	Continued from page 3 and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is NOT MET as evidenced by: 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.	F0801		
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.	F0812		

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F0812 SS = F	Continued from page 4 (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: 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, 07/172026, 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	F0812		

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F0812 SS = F	Continued from page 5 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 staffs 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.	F0812		
F0761 SS = E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit	F0761		

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F0761 SS = E	Continued from page 6 package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: 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 07/20/2026 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 07/20/2026 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 07/22/2026 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 07/22/2026.	F0761		
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints	F0605		

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F0605 SS = D	Continued from page 7 imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or	F0605		

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F0605 SS = D	Continued from page 8 (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.	F0605		

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F0605 SS = D	Continued from page 9 This REQUIREMENT is NOT MET as evidenced by: 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.	F0605		

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F0605 SS = D	Continued from page 10 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.	F0605		
F0690 SS = D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and	F0690		

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F0690 SS = D	Continued from page 11 (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is NOT MET as evidenced by: 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	F0690		

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F0690 SS = D	Continued from page 12 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	F0690		

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F0690 SS = D	Continued from page 13 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.	F0690		
F0756 SS = D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action	F0756		

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F0756 SS = D	Continued from page 14 to protect the resident. This REQUIREMENT is NOT MET as evidenced by: 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	F0756		

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F0756 SS = D	Continued from page 15 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.	F0756		
F0849 SS = D	Hospice Services CFR(s): 483.70(n)(1)-(4) §483.70(n) Hospice services. §483.70(n)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(n)(2) If hospice care is furnished in an LTC facility through an agreement as specified in	F0849		

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F0849 SS = D	Continued from page 16 paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.	F0849		

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F0849 SS = D	Continued from page 17 (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(n)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.	F0849		

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F0849 SS = D	Continued from page 18 (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(n)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, observation, and record review, the facility failed to ensure collaboration with the	F0849		

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F0849 SS = D	Continued from page 19 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 (antianxiety) 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.	F0849		

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F0849 SS = D	Continued from page 20 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: 06/10/20/26 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 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	F0849		

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F0849 SS = D	Continued from page 21 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.	F0849		
F0883 SS = D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and	F0883		

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F0883 SS = D	Continued from page 22 potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is NOT MET as evidenced by: 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	F0883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(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	STREET ADDRESS, CITY, STATE, ZIP CODE
LOCUST GROVE VILLAGE	701 W 6TH STREET , LA CROSSE, Kansas, 67548

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0883 SS = D	Continued from page 23 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.	F0883		