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 _____	07/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOCUST GROVE VILLAGE	701 W 6TH STREET LA CROSSE, KS 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
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey. The 2567 was electronically sent to the facility on 7/3/19.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: The facility had a census of 31 residents. The	F 609		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 07/03/2019

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F 609	Continued From page 1	F 609		

sample included 11 residents, with 3 reviewed for accidents. Based on observation, record review, and interview the facility failed to report a bruise and laceration (cut) to the left eye for 1 of 3 sampled residents. (#11)

Findings included:

- Resident #11's quarterly (MDS) Minimum Data Set assessment, dated 5/10/19, documented the resident had moderately impaired cognition, required extensive assistance of 2 staff for bed mobility, transfers, dressing, toileting and personal hygiene. The assessment documented the resident had unsteady balance, lower extremity functional impairment, 2 injury falls, and 1 non injury fall during the look back period.

The 8/17/18 (CAA) Care Area Assessment for falls documented the resident had a history of falls, unsteady balance, and roamed the facility in his/her wheelchair.

The 5/16/19 care plan directed staff to leave the resident's door open for visualization of the resident when he/she was in his/her bed, pad the bed frame to prevent abrasions, tears and bruises, make sure the automatic locks and anti-roll bar on the wheelchair were working properly, take the resident out of his/her room after rising to continue independence with mobility, place non skid socks on the resident when he/she was out of bed, and keep dysem (a non-slip product) between the cushion and seat of the wheelchair. The care plan documented a protective corner had been added to the resident's desk because the resident bumped his/her arm after getting out of bed, and staff visually checked and monitored the resident

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F 609	Continued From page 2	F 609		

every 15 minutes.

The 5/4/19 fall assessment documented the resident was a high risk for falls.

The 5/25/19 at 10:15 AM, nurse's note documented the resident had a bruise measuring 4 (cm) centimeter x 2 cm and a laceration (cut), measuring 0.5 cm to his/her left eye.

The 5/29/19 investigation documented the resident had a bruise and laceration to his/her left eye, staff cleaned and continue to monitor the area. The investigation documented the resident often grabbed door knobs and handles and often grabbed and pushed the mechanical lifts down the hallway. The investigation documented staff watched the video of the hallway, interviewed staff on duty, and were unable to determine the cause of the bruise and laceration. Staff continued to monitor the resident every 15 minutes.

The 5/29/19 physician order directed staff to monitor the bruise and laceration to the residents outer left eye twice a day.

On 6/27/19 at 7:30 AM, observation revealed the resident sat in a wheelchair by the nurse's station and propelled him/herself into the dining room with staff holding his/her hand.

On 7/1/19 at 10:30 AM, Licensed Nurse G stated the resident independently propelled him/herself all over the facility.

On 7/1/19 at 2:39 PM, Nurse Aide M stated the resident often bumped into things and tried to transfer him/herself into bed, and staff did 15

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F 609	Continued From page 3 minute visual checks on the resident. On 7/1/19 at 2:37 PM, Administrative Nurse D stated he/she was unable to determine how the resident received the bruise and laceration because the resident propelled him/herself independently and bumped into different things. Administrative Nurse D stated he/she thought the resident had bumped his face on a mechanical lift because the resident liked to grab the lifts and pull them down the hall. Administrative Nurse D verified he/she had not reported the bruise of unknown origin to the State agency. The facility's Freedom of Abuse, Neglect, and Exploitation policy, dated 7/17, documented to aid in abuse prevention, all personnel are to report any signs and symptoms of abuse/neglect to their supervisor or to the (DON) Director of Nursing immediately. The policy further documented examples to be reported are lacerations, bruises, and all accident and incidents with the potential to meet the definitions of abuse, neglect, and misappropriation of resident property. These would be investigated promptly by the administrator or designee and an incident report completed. The charge personnel should complete an initial investigation as follow-up and the investigation incident report will be provided no later than 24 hours after the occurrence and an initial report was sent to the State agency. The facility failed to report Resident #11's bruise and laceration of unknown origin to the State agency.	F 609		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		

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F 812	Continued From page 4 §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. (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: The facility had a census of 31 residents. The sample included 11 residents. Based on observation, record review, and interview the facility failed to prepare, store, and serve meals under sanitary conditions in 1 of 1 kitchen, for the 31 residents who received meals from the kitchen. Findings included: - On 6/26/19 at 12:45 PM, observation revealed the cupboards above the steam table, and above the counter on the east wall had brown residue on the bottom. The floor by the entrance into the kitchen, under the steam table, around the bottom of 2 preparation tables in the middle of the room, along the oven, under the 3 compartment sink, and the wall leading into the dishwasher	F 812		

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F 812	Continued From page 5 room had approximately 3 inch wide brown/grime substance. The mop boards around the entire kitchen had blackish substance on them. The pipes underneath the 3 compartment sink had black substance on them. On 6/26/19 at 1:00 PM, Dietary Staff BB verified the findings along the cupboards, the floors under the steam table, in front of the oven, and walls leading into the kitchen and dishwasher room had brown/grime substance. He/she also verified the mop boards all around the kitchen had blackish substance on them. Dietary Staff BB stated the kitchen was mopped twice a day by dietary staff, then the housekeeping department used a machine to deep clean the floors. The facility's Sanitation policy, dated 4/06, documents all kitchen areas and dining areas shall be kept clean, free of litter and rubbish and protected from rodents, roaches, flies, and other insects. A cleaning schedule shall be maintained by the dietary manager. The facility failed to prepare, store, and serve meals under sanitary conditions for residents who receive meals from the kitchen.	F 812		
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: The facility had a census of 31 residents. The sample included 11 residents. Based on	F 921		

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F 921	Continued From page 6	F 921		

observation, record review, and interview the facility failed to provide a safe, clean, comfortable environment for the 31 residents residing in the facility.

Findings included:

- On 6/26/19 at 12:50 PM, during initial tour, observation in the east shower room revealed a shower grab bar at the back of the shower, each end with a reddish orange substance, approximately 2 inches wide going down the wall onto the floor. Further observation in the east shower revealed a container of sani cloth disinfectant wipes in a bag fastened to the back of a mechanical lift.

On 6/26/19 at 1:00 PM, observation of the west shower room revealed an unlocked cabinet containing the following:
2- 11 (oz) ounce shaving cream cans with the label keep out of reach of children
1- 4 oz thera calazinc body shield (skin protectant) with the label for external use only
1- 3 oz black shave gel for men with the label to avoid contact with eyes, open or irritated skin
1- 6 oz black body spray fragrance for men with the label flammable, avoid use on broken or irritated skin and keep out of reach of children.
1- 8 oz bath and body pear blossom body spray with the label keep away from flame or high heat
1- 6 oz Vitamin A and D skin protectant ointment with the label for external use only

On 6/26/19 at 12:59 PM, Nurse Aide N stated the shower room are always unlocked but personal products should be locked up.

On 6/26/19 at 1:05 PM, Administrative Nurse D

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F 921	Continued From page 7 verified the above chemicals were to be locked in a cabinet. A policy for bathing and grooming products was not provided by the facility. The facility failed to provide a safe, hazard free, sanitary environment, placing the residents at risk for accidents.	F 921		