STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N083001	A. BUILDING: _____ B. WING _____	08/11/2022

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) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of the licensure resurvey for the above named facility conducted on 08/10/22 and 08/11/22.	S 000		
S3085 SS=E	26-41-202 (a) Negotiated Service Agreement (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-41-202 (a) The facility reported a census of 12 residents. The sample included 3 residents and 2 focused review residents. Based on record review, observation and interview for 2 sampled residents (R) 100 and R311 and 2 focused review residents R901 and R902, Administrator A	S3085		

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failed to ensure the Negotiated Service Agreement (NSA) completed for residents who required health care services identified a description of the services the resident will receive.

Findings included:

- Record review for R100 revealed she admitted on 07/01/22 with diagnoses of Alzheimer's disease, arthritis, vitamin deficiency and hypokalemia.

R100's "Functional Capacity Screen" dated 06/23/22 recorded the resident as independent with dressing, toileting, transfer, walk/mobility and eating, supervision required for bathing, and physical assistance required for management of medications and treatments. R100 had short- and long-term memory impairment, memory/recall impairment and impaired decision making. Resident was sometimes understandable/ understood.

The resident's "Negotiated Service Agreement" (NSA) dated 07/01/22 recorded R100 required prompting from staff with bathing and staff to administer medications. The NSA failed to identify the use of a bed alarm.

The resident's "Health Service Plan" dated 07/01/21 recorded R100 required prompting from staff with bathing and staff to administer medications. The plan failed to identify the use of a bed alarm.

Observation on 03/11/22 at 11:47 AM revealed a bed alarm on R100's bed. Certified Nurse Aide

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(CNA) C confirmed R100's bed alarm was activated while resident is in bed for safety.

- Record review for R311 revealed she admitted on 08/01/22 with diagnoses of hypertension, diabetes mellitus type 2, depression, chronic obstructive pulmonary disease, restless leg syndrome and atrial fibrillation.

R311's "Functional Capacity Screen" dated 08/01/22 recorded the resident as independent with dressing, toileting, transfer and eating, supervision required for bathing and walk/mobility, and physical assistance with management of medications and treatments. R311 was at risk for falls and had impaired vision.

The resident's "Negotiated Service Agreement" (NSA) dated 08/01/22 recorded R311 required stand-by assistance with bathing and staff to administer medications and treatments. The NSA failed to identify the use of a bed assistive device.

The resident's "Health Service Plan" dated 08/11/21 failed to identify the use of a bed assistive device.

Observation on 08/11/22 at 10:56 AM in R311's room revealed a bed cane attached to the side of the bed. R311 confirmed she used the bed cane at times to get out of bed.

- Record review for R901 revealed she admitted on 05/26/21 with diagnoses of hypertension, peripheral vascular disease and hypothyroidism.

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R901's "Functional Capacity Screen" dated 05/24/22 recorded the resident as independent with bathing, dressing, toileting, transfer, walk/mobility and eating and physical assistance with management of medications.

The resident's "Negotiated Service Agreement" (NSA) dated 05/24/22 failed to identify the use of a bed assistive device.

The resident's "Health Service Plan" dated 05/24/22 failed to identify the use of a bed assistive device.

Observation on 08/11/22 at 11:45 AM in R901's room revealed a bed cane to the side of the bed. R901 confirmed she used the bed cane at times to get out of bed.

- Record review for R902 revealed she admitted on 08/07/20 with diagnoses of hypertension, restless leg syndrome and heart failure.

R902's "Functional Capacity Screen" dated 08/25/21 recorded the resident as independent with toileting, transfer, walk/mobility and eating and physical assistance from staff for bathing, dressing and management of medications.

The resident's "Negotiated Service Agreement" (NSA) dated 08/25/21 failed to identify the use of a bed assistive device.

The resident's "Health Service Plan" dated 08/25/21 failed to identify the use of a bed assistive device.

Observation on 08/11/22 at 11:47 AM in R902's

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S3085	Continued From page 4 room revealed bed canes attached to both sides of the bed. Interview on 08/11/22 at 11:14 AM with Licensed Nurse B confirmed the NSA for R100 lacked a description for a bed alarm. Interview on 08/11/22 at 11:30 AM with Licensed Nurse B confirmed the NSA's for R311, R901 and R902 lacked a description for a bed rail. Administrator A failed to ensure the NSA completed for residents who required health care services identified a description of the services the resident will receive when the NSAs failed to identify residents' use of assistive devices.	S3085		
S3171 SS=E	26-41-204 (i) Health Care Services Standards of Practice (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice. This REQUIREMENT is not met as evidenced by: KAR 26-41-204 (i) The census totaled 12 residents. The sample included 3 residents and 2 focused review residents. Based on observation, interview and record review, Administrator A failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services in accordance with acceptable standards of practice for the use of bed assistive devices,	S3171		

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which met the needs of 1 of 3 sampled residents (R) 311 and 2 of 2 focused review residents R901 and R902.

Findings included:

- The "Resident Roster" obtained on 08/10/22 identified 3 residents as having a bed rail.

Record review for R311 revealed she admitted on 08/01/22 with diagnoses of hypertension, diabetes mellitus type 2, depression, chronic obstructive pulmonary disease, restless leg syndrome and atrial fibrillation.

R311's "Functional Capacity Screen" dated 08/01/22 recorded the resident as independent with dressing, toileting, transfer and eating, supervision required for bathing and walk/mobility, and physical assistance with management of medications and treatments. R311 was at risk for falls and had impaired vision.

The resident's "Negotiated Service Agreement" (NSA) dated 08/01/22 recorded R311 required stand by assistance with bathing and staff to administer medications and treatments. The NSA failed to identify the use of a bed assistive device.

The resident's "Health Service Plan" (HSP) dated 08/11/21 recorded resident required stand by assistance with bathing and staff to administer medications. The HSP failed to identify the use of a bed assistive device.

Record review lacked any assessment of the

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resident to confirm the device was not a restraint, an assessment of the resident to determine the purpose of the bedrail/assistive device and the resident's ability to safely use the device, an assessment of the bedrail/assistive device to ensure the device was securely attached to the bed or bedframe and posed no risk for entrapment.

Observation on 08/11/22 at 10:56 AM in R311's room revealed a bed cane attached to the side of the bed. R311 confirmed she used the bed cane at times to get out of bed.

- Record review for R901 revealed she admitted on 05/26/21 with diagnoses of hypertension, peripheral vascular disease and hypothyroidism.

R901's "Functional Capacity Screen" dated 05/24/22 recorded the resident as independent with bathing, dressing, toileting, transfer, walk/mobility and eating and physical assistance with management of medications.

The resident's "Negotiated Service Agreement" (NSA) dated 05/24/22 failed to identify the use of a bed assistive device.

The resident's "Health Service Plan" dated 05/24/22 failed to identify the use of a bed assistive device.

Record review lacked any assessment of the resident to confirm the device was not a restraint, an assessment of the resident to determine the purpose of the bedrail/assistive device and the resident's ability to safely use the device, an assessment of the bedrail/assistive device to

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ensure the device was securely attached to the bed or bedframe and posed no risk for entrapment.

Observation on 08/11/22 at 11:45 AM in R901's room revealed a bed cane attached to the side of the bed. R901 confirmed she used the bed cane at times to get out of bed.

- Record review for R902 revealed she admitted on 08/07/20 with diagnoses of hypertension, restless leg syndrome and heart failure.

R902's "Functional Capacity Screen" dated 08/25/21 recorded the resident as independent with toileting, transfer, walk/mobility and eating and physical assistance from staff for bathing, dressing and management of medications.

The resident's "Negotiated Service Agreement" (NSA) dated 08/25/21 failed to identify the use of a bed assistive device.

The resident's "Health Service Plan" dated 08/25/21 failed to identify the use of a bed assistive device.

Record review lacked any assessment of the resident to confirm the device was not a restraint, an assessment of the resident to determine the purpose of the bedrail/assistive device and the resident's ability to safely use the device, an assessment of the bedrail/assistive device to ensure the device was securely attached to the bed or bedframe and posed no risk for entrapment.

Observation on 08/11/22 at 11:47 AM in R902's

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S3171	Continued From page 8 room revealed a bed cane to both sides of bed. Interview on 08/11/22 at 11:14 AM with Licensed Nurse B confirmed no safety checks or bed assistive device assessments were completed on R311, R901 and R902. The FDA (food and drug administration) Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment dated 3/10/06 listed 4 zones of greatest concern with specific measurements to reduce the risk of entrapment as follows: Zone 1 within the rail should measure less than 4 and 3/4 inches Zone 2 under the rail, between the rail supports or next to a single rail support should measure less than 4 and ¾ inches Zone 3 between the rail and the mattress should measure less than 4 and 3/4 inches Zone 4 under the rail at the ends of the rail should measure less than 2 and 3/8 inches. Administrator A failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services which met the needs of R311, R901 and R902 regarding use of a bed assistive devices.	S3171		
S3310 SS=F	26-41-207 (b) (5-6) (c) Infection Control Policies (b) (5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and	S3310		

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employee in-service education at least annually on the control of infections in a health care setting; and
(c) Each administrator or operator shall ensure the facility ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105

This REQUIREMENT is not met as evidenced by:
K.A.R 26-41-207 (c)

The census totaled 12 residents. The sample included 3 residents, 2 focused review residents and review of 2 newly hired employees. Based on record review and interview for 3 Residents (R) 100, R311 and R810, the facility failed to ensure compliance with the State Agency's tuberculosis (TB) guidelines.

Findings included:

- Review of R100's "Medical Record" revealed she admitted to the facility on 07/01/22 and the record lacked evidence of completion of a TB questionnaire upon admission.

Review of R311's "Medical Record" revealed she admitted to the facility on 08/01/22 and the record lacked evidence of completion of a TB questionnaire upon admission.

Review of R810's "Medical Record" revealed she admitted to the facility on 03/24/22 and the record lacked evidence of completion of a TB

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S3310	Continued From page 10 questionnaire upon admission. Interview on 08/11/22 at 10:30 AM with Licensed Nurse (LN) B confirmed TB questionnaires were not completed on admission for residents and further confirmed no TB questionnaires completed on admission for R100, R311 and R810. The facility's "Tuberculin Testing" policy dated 01/06/21 recorded, "7. Each resident and employee shall have an annual TB symptom screen that includes completion of the symptom review questionnaire." Policy failed to identify admission TB symptom screening/ questionnaire for residents. The facility failed to ensure compliance with the State Agency's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105, which required TB questionnaires upon admission and had the potential to affect all residents.	S3310		