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	175369	A. BUILDING _____ B. WING _____	09/11/2024

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(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 sent electronically on 09/16/24.	F 000		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: The facility had a census of 36 residents. The sample included 13 residents, with one reviewed for side rails. Based on observation, record review, and interview, the facility failed to ensure a bed rail that met safety requirements and addressed risks for entrapment for Resident (R)4.	F 700		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 09/11/2024

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F 700	Continued From page 1	F 700		

This placed her at risk for accident or injury due to unidentified risks associated with side rail use.

Findings included:

- R4's Electronic Medical Record (EMR) recorded diagnoses of Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, spinal stenosis (degenerative condition of the spine that could cause weakness and loss of use of extremities), and right knee pain.

R4's "Admission Minimum Data Set" (MDS), dated 07/16/24, recorded the resident had a Brief Interview for Mental Status (BIMS) score of 12 indicating mild cognitive impairment. The MDS documented R4 required the assistance of one staff with bed mobility and transfers. The MDS lacked documentation the resident had side rails.

R4's EMR recorded a "Side Rail Assessment" completed on 07/10/24 upon admission. The assessment documented the resident does not transfer independently and the rails were not a high risk for entrapment. The rails and hoops were considered for safety and security, and the resident would need to use the side rail due to her weakness and balance deficit; the rail would help the resident turn side to side, move up and down in bed, pull herself from a laying to sitting position, supporting herself, transferring more safely, exiting the bed more safely, and improving balance. The assessment documented the rails/hoops were recommended due to a family request. Further evaluation was required by physical therapy or occupational therapy to recommend the type of side rail and usage. The

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F 700	Continued From page 2	F 700		

assessment did not document the rail's openings or address the space between the side rail/hoop and the mattress.

R4's EMR lacked evidence that therapy evaluated the type of rail and its usage.

The "Logbook Documentation" provided by the facility revealed the facility's maintenance staff checked the bed and rails on 08/07/24 for cleaning and care, sanitizing methods, environmental conditions for storage and transport as well as a "Maintenance Check." The document recorded the "Maintenance Check" which included inspecting connectors on rails and tightening as necessary; removal of burs or rough edges to prevent injury; verification of the function of the spring knob assembly if applicable and ensuring the latch was free of dirt and/or foreign material that could impair function; ensuring the side rails engaged and locked as specified; tightening, adjusting, or replacing any parts such as end caps, knobs, bolts, screws etc. that were loose or showed signs of wear, or were missing. The check did not address the rail opening, or the area between the rail and mattress.

On 09/10/24 at 04:00 PM, observation revealed a one-fourth side rail on the left side of R4's bed with an opening approximately 16.5 inches by 32 inches. Continued observation and examination revealed the side rail was able to slip out of the bed and move. The resident had her own personal full-size mattress and used a remote control to elevate the head of the bed and change the bed position at the foot of the mattress.

On 09/11/2024 at 10:00 AM, Administrative Nurse E verified the bed rails on R4's bed had too large

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of an opening, and the rail was not able to be affixed to the bed securely for stability and was able to be moved easily. Administrative Nurse A verified the facility lacked any further assessment for the use of the side rail.

The "Bed Safety" policy, dated 2014, documented the facility strives to provide a safe sleeping environment for the resident. The resident's sleeping environment would be assessed by the interdisciplinary team, to consider the resident's safety, medical conditions, comfort, and freedom of movement, as well as input from the resident and family regarding previous sleeping habits and bed environment. To try to prevent deaths/injuries from the beds and related equipment (including frame, mattress, side rails, headboard, footboard, and bed accessories), the facility shall promote the following approaches:
Inspection by the maintenance staff of all beds and related equipment as part of our regular bed safety program to identify risks and problems including potential entrapment risks.
Review that gaps within the bed system are within the dimensions established by the Federal Drug Administration (FDA) The review shall consider situations that could be caused by the resident's weight, movement, or bed position.
Ensure that the bed rails are properly installed using the manufacturer's instructions or other pertinent safety guidance to ensure proper fit.
Identify additional safety measures for residents who have been identified as having a higher than usual risk for injury including entrapment such as altered mental status, or restlessness.
Maintenance will document this review in the TELS program.
The facility's education and training activities would include instruction about risk factors for

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F 700	Continued From page 4 resident injury due to beds, and strategies for reducing risk factors for injury, including entrapment. If side rails were used, there would be an interdisciplinary assessment of the resident, consultation with the Attending Physician, and input from the resident and/or legal representative. The staff would obtain consent for the use of the side rails from the resident or the resident's legal guardian. Before using the side rails for any reason, the staff shall inform the resident and family about the benefits and potential hazards associated with the side rails. The facility failed to adequately assess R4's actual rail in use to ensure safe openings and failed to assess for safe use of a side rail prior to placing it on R4's bed. This placed her at risk for accident or injury due to unidentified risks associated with side rail use.	F 700		
F 756 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.	F 756		

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(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 to protect the resident.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 36 residents. The sample included 13 residents, with five reviewed for unnecessary medications. Based on observation, interview, and record review, the facility failed to ensure the Consultant Pharmacist (CP) identified and reported the lack of a 14-day stop date or specified duration, for Resident (R)10's as needed (PRN) antianxiety (class of medications that calm and relax people) medication. This placed R10 at risk for unintended effects related to psychotropic drug medications.

Findings include:

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- R10's Electronic Health Record (EHR) revealed diagnoses of dementia (a progressive mental disorder characterized by failing memory, and confusion), major depressive disorder (major mood disorder that causes persistent feelings of sadness), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear).

R10's "Quarterly Minimum Data Set" (MDS), dated 07/05/24, recorded R10 had severely impaired cognition. The MDS recorded he required extensive assistance from two staff with bed mobility and transfers. The MDS lacked documentation R10 received an antianxiety medication during the observation period.

R10's "Care Plan," dated 07/25/24, recorded R10 required extensive assistance with most activities of daily living (ADL) care. R10's "Care Plan" documented the resident received lorazepam (antianxiety medication) for anxiety and restlessness.

R10's "Physician's Order," dated 07/25/24, directed the staff to administer lorazepam 0.5 milligrams (mg) to 3 mg, three times a day (morning, afternoon, and at bedtime) PRN. The order lacked a stop date.

R10's EHR lacked evidence of a specified duration which included a physician's rationale for the extended use of the PRN lorazepam.

The Consultant Pharmacist's monthly review for R10 completed on 08/19/24 lacked evidence the CP identified the PRN lorazepam with no stop date.

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On 09/10/24 at 07:45 AM, R10 sat in a wheelchair at the dining room table. Certified Medication Aide (CMA) R administered the resident's medication.

On 09/11/24 at 11:00 AM, Administrative Nurse D verified the resident received lorazepam PRN, with a physician order date of 07/25/24, and no stop date. Administrative Nurse D verified the Consultant Pharmacist had sent monthly reviews to the facility and lacked a recommendation for the 14-day stop date or rationale for continued use of the medication.

The facility's "Pharmacy Services- Role of the Consulting Pharmacist" policy, dated March 2023 documented the facility would contract the services of the Consulting Pharmacist. The Consulting Pharmacist shall provide consultation on all aspects of pharmacy services in the facility, including identifying pertinent resources and references about medications and their proper use and monitoring in the population. The Consultant Pharmacist would review the medication regimen of each resident at least monthly, or more frequently under certain conditions, based on applicable federal and state guidelines. Appropriate communication of information to prescribers and facility leadership about potential or actual problems related to any aspect of medications and pharmacy services, including medication irregularities, pertinent resident-specific documentation irregularities, and pertinent resident-specific documentation in the medical record, as indicated.

The facility failed to ensure the CP identified and reported the lack of a 14-day stop date for the use of PRN lorazepam for R10. This placed the resident at risk for unnecessary psychotropic

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F 756	Continued From page 8 medication.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §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 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	F 758		

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§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.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 36 residents. The sample included 13 residents, with five reviewed for unnecessary medications. Based on observations, interviews, and record review, the facility failed to ensure a 14-day stop date or a specified duration with rationale for Resident (R)10's ongoing as-needed (PRN) antianxiety (class of medications that calm and relax people) medication. This placed R10 at risk for unintended effects related to psychotropic (alters mood or thought) drug medications.

Findings include:

- R10's Electronic Health Record (EHR) revealed diagnoses of dementia (a progressive mental disorder characterized by failing memory, and confusion), major depressive disorder (major mood disorder that causes persistent feelings of sadness), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear).

R10's "Quarterly Minimum Data Set" (MDS), dated 07/05/24, recorded R10 had severely

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F 758	Continued From page 10	F 758		

impaired cognition. The MDS recorded he required extensive assistance from two staff with bed mobility and transfers. The MDS lacked documentation R10 received an antianxiety medication during the observation period.

R10's "Care Plan," dated 07/25/24, recorded R10 required extensive assistance with most activities of daily living (ADL) care. R10's "Care Plan" documented the resident received lorazepam (antianxiety medication) for anxiety and restlessness.

R10's "Physician's Order," dated 07/25/24, directed the staff to administer lorazepam 0.5 milligrams (mg) to 3 mg, three times a day (morning, afternoon, and at bedtime) PRN. The order lacked a stop date.

R10's EMR lacked evidence of a specified duration which included a physician's rationale for the extended use of the PRN lorazepam.

On 09/10/24 at 07:45 AM, R10 sat in a wheelchair at the dining room table. Certified Medication Aide (CMA) R administered the resident's medication.

On 09/11/24 at 11:00 PM, Administrative Nurse D verified the resident received lorazepam PRN, with a physician order date of 7/25/24. Administrative Nurse D verified the order did not have a 14-day stop date or a reason for the continued use with the appropriate rationale.

The facility did not provide a policy related to PRN psychotropic medications.

The facility failed to ensure R10 was free of unnecessary psychotropic drugs when they failed

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F 758	Continued From page 11 to obtain a stop date for the use of PRN lorazepam. This placed R10 at risk for adverse side effects from the continued use of psychotropic medications.	F 758		
F 761 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 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: The facility had a census of 36 residents. Based on observation, interview, and record review the facility failed to store biologicals as required when staff failed to discard or destroy expired	F 761		

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F 761	Continued From page 12	F 761		

medications and vaccines. This deficient practice placed residents of the facility at risk of receiving ineffective medications.

Findings included:

- On 09/09/24 at 09:33 AM, observation revealed Certified Medication Aide (CMA) M obtained medication to administer to residents from the "Shade" medication cart. The cart contained one bottle of multivitamins with minerals which had no expiration date.

On 09/09/24 at 09:40 AM, Licensed Nurse (LN) G opened the medication storage room, and observation in the medication refrigerator revealed three bisacodyl (laxative) suppositories that expired 07/2024; three bisacodyl suppositories that expired 05/2024; three boxes of Fluzone quadrivalent vaccines (flu shot), expired 06/2024 and two boxes of Fluzone high dose vaccines, expired 06/2024. LNG verified the expiration dates.

On 09/09/24 at 11:00 AM, Administrative Nurse D verified staff were to remove from stock or dispose of expired medications.

The facility's "Storage of Medications" policy, dated 04/2014, stated drug containers that had missing, incomplete, or incorrect labels should be returned to the pharmacy for proper labeling. The policy stated the facility should not use discontinued or outdated drugs or biologicals and all such drugs would be returned to the dispensing pharmacy or destroyed.

The facility failed to discard or destroy expired medications and vaccines, placing residents of

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F 761	Continued From page 13 the facility at risk of receiving ineffective medications.	F 761		
F 801 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 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	F 801		

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	175369	A. BUILDING _____ B. WING _____	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOCUST GROVE VILLAGE	701 W 6TH STREET LA CROSSE, KS 67548

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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, and food purchasing/receiving; and
(ii) In States that have established standards for food service managers or dietary managers,

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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:
The facility had a census of 36 residents. The sample included 13 residents. Based on observation, interview, and record review the facility failed to employ a full time Certified Dietary Manager (CDM) to supervise the preparation of meals and sanitation in the facility's kitchen. This deficient practice placed the 36 residents of the facility at risk for inadequate nutrition.

Findings included:

- On 09/10/24 at 12:00 PM, observation revealed Dietary Staff (DS) BB in the facility kitchen assisting with the noon meal service.

On 09/10/24 at 12:45 PM, Dietary Staff (DS) BB stated the prior Registered Dietician (RD) had assisted her with training related to the CDM certification. She stated she had completed the courses and was scheduled to take the test in November 2024.

The facility's "Dietary Manager" policy stated the dietary manager was a certified dietary manager licensed by this state in accordance with the American Dietetic Association rules, regulations and guidelines. The policy stated the dietary manager was responsible for the day-to-day functions of the dietary department. The policy stated during the completion of the CDM course, the RD would provide on-site visits weekly.

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F 801	Continued From page 16 The facility failed to employ a full time CDM to supervise the preparation of meals and sanitation in the facility's kitchen, placing the 36 residents of the facility at risk for inadequate nutrition.	F 801		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: The facility had a census of 36 residents. The sample included 13 residents. Based on observation, interview, and record review the facility failed to provide food prepared by methods that conserve nutritive value, flavor, and appearance when dietary staff failed to measure and provide the proper amounts of food for the four residents with a pureed diet. This placed the four residents at risk for impaired nutrition. Findings included: - On 09/10/24 at 11:20 AM, observation revealed Dietary Staff (DS) CC prepared the pureed foods for four residents. DS CC placed several ladles of meatloaf into the mixer without measuring the amount. DS CC then added approximately one-half cup of juice from the pan of vegetables before pureeing the mixture. She did not measure the pureed meatloaf when placing it in a cup for	F 804		

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each resident. DS CC then pureed two cups of scalloped potatoes with one-half cup of vegetable juice and did not measure the servings when placed in resident cups. DS CC pureed one cup of squash with a fourth cup of vegetable juice and did not measure the serving size for each resident.

On 09/10/24 at 11:20 AM, DS CC stated she did not have recipes for the pureed foods and stated she "just eyeballed the amounts" instead of measuring.

On 09/10/24 at 12:45 PM, Dietary Staff (DS) BB stated should follow recipes for pureed foods and measure portions when serving pureed. She stated the Registered Dietician taught them to measure food before the pureed process.

The facility's "Standardized Recipes" policies, dated 11/2023, stated a file of tested, standardized recipes, adjusted to appropriate yield, was used in the preparation of foods. The recipe file was maintained in the kitchen and was available to cooks throughout their tour of duty. Recipes are periodically reviewed for revisions and updating.

The facility's "Recommendations for Preparing Pureed Foods" directed staff to place one serving of food per serving in the food processor and puree the food item until it is as smooth as possible. If it is too thin add food thickener a little at a time until consistency is reached. When serving pureed food, the quantities may be more or less than the original volume you started with so you may not need to give them all of it. The suggested liquids to use when pureeing foods directed staff to use a broth for meats and

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F 804	Continued From page 18 vegetable juice milk, or a broth for other foods. The facility failed to provide food prepared by methods that conserve nutritive value, flavor, and appearance while preparing the pureed diet. This placed the affected residents at risk for impaired nutrition.	F 804		