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 08/14/2025

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
F0000	INITIAL COMMENTS The following citations represent the findings of a partial extended survey for complaint investigation 1449762. On 08/14/25 at 01:45 PM, Administrative Nurse D received a copy of the "Immediate Jeopardy [IJ] Template" and was notified that the facility's failure to ensure R1 remained free from abuse placed R1 in immediate jeopardy. The facility submitted an acceptable immediate jeopardy removal plan on 8/14/25 at 04:35 PM which included the following: Social Services would follow up immediately with R1 regarding her psychosocial wellness and continue to offer R1 support regarding the incident. The facility staff would be re-educated on Abuse, Neglect, and Exploitation, completed on 08/14/25. Administrative Nurse D interviewed all alert and oriented residents to establish residents' safety, and the residents felt free from staff abuse and neglect on 08/14/25. The facility held a Quality Assurance and Performance Improvement (QAPI) meeting immediately concerning the incident. The facility notified R1's primary care provider and R1's responsible party on 06/28/25. The facility notified Law Enforcement on 07/09/25 and the medical director on 08/14/25. The corrective actions to remove the immediacy were verified onsite on 08/14/25 at 06:00 PM. The scope and severity remained at a "G" (isolated, actual harm).	F0000		
F0600 SS = SQC-J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation	F0600		

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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F0600 SS = SQC-J	Continued from page 1 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)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: The facility identified a census of 34 residents, with three residents reviewed for abuse, neglect, and exploitation. Based on record review, observation, and interview, the facility failed to prevent an episode of staff-to-resident physical abuse. On 06/28/25 at approximately 06:40 PM, Certified Nurse Aide (CNA) M took cognitively impaired Resident (R)1 to the bathroom. CNA M called for assistance, and CNA N came to R1's room. CNA M told CNA N that R1 bit her, so CNA N took over care. CNA N noticed R1 was dabbing her face with toilet paper, and the toilet paper had blood on it. CNA N asked R1 what happened, and R1 said, "Honey, can you believe it? Her fist hit my jaw." CNA N observed a purple bruise on R1's right jaw and blood in the resident's mouth. CNA N informed LN G and CNA M of R1's statement. CNA M denied hitting R1. Following the incident, R1 became scared and paranoid to be in her room, afraid "she" was there, and did not want anyone to touch her. The facility's failure to prevent the staff-to-resident physical abuse placed R1 in immediate jeopardy. Findings included: - R1's Electronic Medical Record (EMR) documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion) without behavioral disturbance, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), hypertension (high blood pressure), and pain. R1's "Annual Minimum Data Set," dated 06/20/25, documented R1 had a Brief Interview for Mental Status (BIMS) score of four, which indicated severe cognitive impairment. The MDS documented R1 required supervision	F0600		

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F0600 SS = SQC-J	Continued from page 2 with eating, oral hygiene, toilet transfer, and ambulation. The MDS documented R1 was dependent on staff for bathing and required moderate to extensive assistance with toileting, dressing, personal hygiene, and sitting to lying. The MDS documented R1 had no physical behaviors directed towards others during the lookback period; R1 had verbal behaviors one to three days during the lookback period. The “Cognitive Loss/Dementia Care Area Assessment (CAA),” dated 06/20/25, documented R1 had severe cognitive impairment due to dementia with behaviors. R1’s behaviors included verbal behavior towards others and wandering. R1’s communication ability was impacted by cognitive impairment and hearing problems. R1 required staff assistance with activities of daily living. The “Behavioral Symptoms CAA,” dated 06/20/25, documented R1 had wandering and verbal behaviors directed towards others one day during the lookback period. R1’s behaviors did not interfere with other residents or place R1 at risk. R1’s behaviors were easily redirectable by giving foods and fluids. The “Psychosocial Well-Being CAA,” dated 06/20/25, documented R1 had insomnia, mood swings, restlessness, agitation, and anxiety. R1’s anxiety was due to her dementia and limited ability to comprehend and cope. The CAA noted observation of R1’s non-verbal communication was important, as R1 conveyed her moods by facial expressions and body language. R1 liked to be around others, talk, and hold hands with staff and other residents. R1’s “Care Plan” directed staff R1 needed guidance, cues, and assistance with activities of daily living, and to allow R1 to do what she could (01/06/25). The care plan directed staff if R1 seemed anxious to help R1 to an area with less noise and activity (03/28/25). R1's "Care Plan" documented interventions that directed staff R1 had dementia, and to allow her to make choices and decisions as much as R1 was able; R1 liked to spend time in the living areas visiting and talking to other residents and staff (06/20/25). The “Care Plan” lacked interventions related to behaviors prior to the incident on 06/28/25. The “Weekly Skin Assessment on 06/16/25, documented R1’s skin was warm and dry, with no skin issues noted. The “Progress Note,” dated 06/28/25 at 07:30 PM,	F0600		

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F0600 SS = SQC-J	Continued from page 3 documented R1 stated she had to go to the bathroom, and staff attempted to take her. R1 became agitated and started swinging and hitting at the staff. After the incident, R1 had a small bruise to her chin and scratches to her cheek. Staff applied an ice pack to the resident's chin. The note recorded staff notified Administrative Nurse D and planned to notify R1's physician. The “Progress Note,” dated 06/28/25 at 09:13 PM, documented staff notified R1’s responsible party of the incident, and LN G explained R1 was combative during toileting and R1 had a bruise on her chin. R1’s responsible party was understanding and stated the resident could get that way sometimes. The “Progress Note,” dated 06/28/25 at 11:36 PM, documented the bruising on R1’s chin was purple in color and more prominent. R1 was agitated and wanted out of bed. Staff assisted R1 to the toilet, then to her wheelchair, and gave her fluids. R1 left the ice pack on her chin for about twenty minutes. Licensed Nurse (LN) G’s “Notarized Witness Statement,” dated 06/28/25, documented at approximately 06:45 PM, CNA M approached LN G and reported R1 bit her neck. LN G noted CNA M's neck was red on the left side, but there were no bite marks. LN G documented CNA N said CNA M hit R1. CNA N then showed LN G pictures of R1. CNA M stated her hands were down and she did not hit R1. LN G noted she asked CNA M to leave. After CNA M left, LN G went to R1’s room. R1 was in her wheelchair. LN G documented the right side of R1’s chin was red with a bruise forming, and R1’s right cheek had some scratches. There was also an abrasion on R1's right cheek. LN G noted the left lower side of R1's teeth and gumline had blood visible. LN G applied a cool cloth to R1’s chin, then notified Administrative Nurse D of the event. LN G took pictures of R1 and sent them to Administrative Nurse D. CNA N’s “Notarized Witness Statement,” dated 06/28/25, documented CNA N heard on the radio R1 was biting, hitting, and shaking. CNA N went to R1’s room and, as she turned into the bathroom, CNA M flung herself against the bathroom wall. CNA N asked what was going on, and CNA M stated she was trying to get R1 into her pajamas when R1 bit her neck. CNA N told CNA M to show her neck to LN G and tell her what happened, so LN G could document the behavior. CNA N knelt in front of R1, who was dabbing her face with toilet paper. CNA N noticed the toilet paper had blood on it and asked R1 what happened. R1 responded, “Honey, can you believe it? Her fist hit my jaw.” CNA N stated she could see a	F0600		

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F0600 SS = SQC-J	Continued from page 4 purple bruise and blood in R1's mouth. CNA N then told CNA O that R1 reported CNA M hit her. CNA N took a picture of R1's face and walked to the nurse's station, where CNA M was talking to LN G. CNA N told CNA M and LN G they needed to talk privately. CNA N showed CNA M and LN G the picture and reported that R1 said CNA M hit her. CNA M stated she did not hit R1; her hands never touched R1. CNA N asked CNA M how R1 got the marks on her face and bleeding. LN G told CNA M she had to go home while this (incident) was investigated. LN G and CNA N went to R1's room. LN G assessed R1's face. R1 reached out and cupped CNA N's face and stated, "Honey, I don't know why that kid did that to me." R1 stated, "She hit my face and then bit me like this," as R1 leaned forward to demonstrate what happened. CNA N asked R1, "So she hit you and bit you?" R1 stated, "Yes, honey, she did. I told her, no, stop that, and she wouldn't, so I hit her. I didn't want to hit her, but I had to, honey." CNA N then stated later she took R1 to her room, and R1 was scared, looking around the room and asking if CNA M was there. CNA N reassured R1 that CNA M went home. CNA N documented she stayed with R1, as R1 acted "paranoid". The "Progress Note," dated 06/29/25 at 11:36 PM, documented R1 had a dark purple bruise on her chin and down her neck. R1's lower lip and right lower cheek area were edematous (swollen). R1 did not complain of pain to the area but touched the area to her chin at times. The "Weekly Skin Assessment," dated 06/30/25, documented a bruise to R1's right elbow. R1 had bruising and swelling to her lip, chin, right cheek, and upper neck. The "Facility Incident Report," dated 06/30/25, documented on 06/28/25 at approximately 06:40 PM R1 approached the nurse workstation and requested to use the bathroom. CNA M wheeled R1 to her room. Once in the bathroom, CNA M reported R1 became combative and bit her on the left neck region. CNA M called for assistance, and CNA N responded and relieved CNA M to report the incident to LN G. R1 dabbed her face with toilet paper, and when it was removed, there was blood on it. R1 reported, "Honey, can you believe it? Her fist hit my jaw." Staff observed a purple bruise on R1`s chin, and blood on her mouth. CNA N requested assistance from CNA O and reported R1's claims to LN G. LN G received reports from CNA M and CNA N. CNA M was dismissed from the shift pending further investigation. The staff completed a thorough examination of R1. The right side of R1's chin had a red area, with a bruise forming, and she had blood in her gumline. R1's right	F0600		

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F0600 SS = SQC-J	Continued from page 5 cheek had scratches on it and a little abrasion. The staff notified Administrative Staff A, Administrative Nurse D, R1's primary care physician, and R1's responsible party. The facility report documented upon review of all statements and descriptions of the incident, the facility could not conclude without a doubt that abuse, neglect, and exploitation took place. CNA M's "Notarized Witness Statement," dated 07/01/25, documented CNA M sat at the nurse's desk when R1 came to the desk in her wheelchair and asked for help to use the bathroom. In the bathroom, R1 took hold of the rails, stood up, and stated, "Hurry up and pull my pants down." CNA M stated she asked R1 to turn, and said she would help with that as soon as she got the wheelchair out of the bathroom. CNA M got R1's slacks down, but not her underwear, and R1 sat down. CNA M asked R1 to please stand back up so CNA M could pull her underpants down, and R1 cursed and said she was about to urinate right then. CNA M told R1 she would help her to stand back up so she could pull R1's underwear down. CNA M put her arms underneath R1's arms and lifted R1 with R1's head on her left side. CNA M documented R1 bit her on the neck as CNA M pulled R1's pants down. CNA M called LN G and told LN G that R1 was biting and kicking. As CNA M waited for a response, CNA M told R1 she was going to change her shirt into pajamas and took R1's shirt off. CNA N came to R1's bathroom, and CNA M showed CNA N her neck. CNA N told CNA M to show LN G her neck and tell LN G what happened. A few minutes later, CNA N came to the desk and asked LN G and CNA M to talk in private. CNA N showed them a picture of a bruise on R1's chin area, stated it was unacceptable, and reported R1 said, "That girl hit me with her fist." CNA M noted she asked CNA N how she could hit R1 in the face when her hands were busy pulling down R1's slacks and underwear. CNA M noted that LN G told her to go home pending the investigation, so CNA M returned the radio, clocked out, gathered her stuff, and left. CNA P's "Notarized Witness Statement," dated 08/14/25, documented CNA P came into work the night shift on 06/28/25. R1 was in the living room. CNA P obtained report about what had happened. CNA P documented R1 was "worked up" and visibly upset. Later that night, CNA P took R1 to her room to lie her down, and when R1 entered the room, R1 repeatedly said she was scared to be in her room and asked if "she" was there. CNA P asked R1 who she was talking about, and R1 said she was afraid of the lady who hit her. CNA P documented R1 was really upset and scared about staying in her room, so CNA P brought R1 back to the living room. Later that night, CNA P was eventually able to convince R1 that	F0600		

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F0600 SS = SQC-J	Continued from page 6 CNA M was not there, and R1 agreed to lay down for the night. CNA P documented R1's face had a cut that looked like a (finger) nail had dug in, R1's face had started to bruise, and her lip was swollen. LN H's "Notarized Witness Statement," dated 08/14/25, documented the day after the incident, R1 did not want anyone to touch her. R1 sat at the nurse's desk and stated she could not believe the woman hit her. LN H documented R1's mouth still had blood in it and her lip was puffy and purple. R1 was guarded about anyone touching her or doing care, which was abnormal behavior. CMA R's "Notarized Witness Statement," dated 08/14/25, documented CMA R came into work the day after the incident at 05:40 AM. R1 was already awake and in her wheelchair. CMA R stated she immediately saw a large bruise on the right side of R1's face and a swollen lower lip. CMA R asked LN G what happened to R1, and LN G stated a staff member hit R1 the night before. CMA R started to talk with R1, and R1 stated, "I can't believe she did that to me. She hit me, sweetheart. Why would anyone want to hurt me?" On 08/14/25 at 10:00 AM, observation revealed R1 sat in her wheelchair in front of the nurse's desk with a lap blanket over her lap. R1's head was forward, and she leaned her chin on her hand. When addressed, R1 looked up, smiled, and said, "Boo." On 08/14/25 at 10:15 AM, CMA R stated she came in the morning after the incident, and there was no doubt in her mind R1 had been punched. CMA R stated the whole right side of R1's jaw was black and purple, and she had a fat lip, and there was still blood on her lip. CMA R stated R1 had never had behavioral issues directed towards others and stated if R1 had bitten CNA M, she had to have been provoked. CMA R stated R1 was still talking about the incident the next morning and stated, "That girl hit me," and "She's not here, is she?" On 08/14/25 at 10:30 AM, LN H stated she was the nurse on the next morning after the incident happened, and it appeared R1 had been hit with a fist. R1 had significant black/purple bruises to the right side of her face, and her jaw and lower lip were swollen. LN H stated R1 came up to her in her wheelchair and asked her if she was going to hit R1 too. LN H stated that it broke her heart when R1 asked her that. On 08/14/25 at 12:00 PM, CNA P stated she had come into work on the night shift after the incident, and R1's	F0600		

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F0600 SS = SQC-J	Continued from page 7 chin was dark purple, and her lip was swollen. CNA P stated R1 was guarded with anyone touching her, and when staff approached R1, she put up her arm to protect herself, like she was scared she was going to be hit again. CNA P stated she had no doubt R1 had been hit in the face. On 08/14/25 at 01:00 PM, Administrative Nurse D stated the facility could not prove that CNA M hit R1 because there was a handrail on the right side of the toilet, and if R1 had reached up and bit CNA M, then came back down and hit her face on the handrail, which would explain her injuries. Administrative Nurse D stated they did not have to fire CNA M because CNA M already put in her two weeks' notice, and she just did not come back to work. Administrative Nurse D stated she interviewed the staff who worked after the incident, but they had not told her anything about suspecting CNA M hit R1. Administrative Nurse D confirmed R1's "Care Plan" did not had anything about R1 being physically aggressive towards others until after the incident. The facility's "Freedom from Abuse, Neglect, and Exploitation Policy," dated August 2022, documented it is the policy of the facility that each resident will be free from abuse. Our residents have the right to be free from abuse, neglect, exploitation, misappropriation of property, and mistreatment by a court of law. Residents have the right to be free from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to meet the resident's medical symptoms. The policy included all seven required components. On 08/14/25 at 01:45 PM, Administrative Nurse D received a copy of the "Immediate Jeopardy [IJ] Template" and was notified that the facility's failure to ensure R1 remained free from abuse placed R1 in immediate jeopardy. The facility submitted an acceptable immediate jeopardy removal plan on 8/14/25 at 04:35 PM which included the following: Social Services would follow up immediately with R1 regarding her psychosocial wellness and continue to offer R1 support regarding the incident. The facility staff would be re-educated on Abuse, Neglect, and Exploitation, completed on 08/14/25. Administrative Nurse D interviewed all alert and oriented residents to establish residents' safety, and the residents felt free from staff abuse and neglect on 08/14/25.	F0600		

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F0600 SS = SQC-J	Continued from page 8 The facility held a Quality Assurance and Performance Improvement (QAPI) meeting immediately concerning the incident. The facility notified R1's primary care provider and R1's responsible party on 06/28/25. The facility notified Law Enforcement on 07/09/25 and the medical director on 08/14/25. The corrective actions to remove the immediacy were verified onsite on 08/14/25 at 06:00 PM. The scope and severity remained at a "G" (isolated, actual harm).	F0600		