STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175114	A. Building B. Wing	02/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Diversicare of Hutchinson	1202 E 23rd Avenue Hutchinson, KS 67502

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 37 residents. The sample included seven residents, with one resident reviewed for dementia (progressive mental disorder characterized by failing memory, confusion), care, and services. Based on observation, record review, and interviews, the facility failed to initiate a dementia plan of care that identified and honored Resident (R) 1's desire for physical engagement, which included direction to staff on how to identify voluntary engagement, and how to monitor for potential negative outcomes associated with physical engagement. Findings included:- R1's Electronic Health Record (EHR) under the Census tab documented R1 admitted to the facility on [DATE].R1's EHR revealed diagnoses of dementia, major depressive disorder (a major mood disorder that causes persistent feelings of sadness), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and unspecified sexual dysfunction.R1's 09/28/25 Modified admission Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) interview could not be completed. Per staff interview, R1 had severely impaired cognition. The assessment documented R1 displayed no behavior towards herself or others. She utilized a manual wheelchair and/or walker for locomotion. The assessment documented R1 required supervision or touching assistance for eating, and otherwise, R1 was dependent on staff assistance for all care. R1's 09/28/25 Cognitive Loss / Dementia Care Area Assessment (CAA) documented R1 was unable to participate in the BIMS interview due to severe cognitive impairment. R1 was inattentive and had disorganized thinking processes.R1's 09/25/25 Care Plan had a Focus dated 01/16/26 which noted R1 had potential to be physically aggressive related to her diagnosis of dementia and provided the following interventions, all dated 01/16/26:Staff would administer medications as ordered and monitor/document side effects (unintended reaction to medication) and the effectiveness of medications.Staff would analyze times of day, places, circumstances, and triggers as well as what measures de-escalated behaviors and document the responses.Staff would assess and address contributing sensory deficits.Staff would anticipate R1's needs (hunger, thirst, toileting needs, comfort level, body positioning, pain, etc.).Staff would provide physical and verbal cues to alleviate anxiety, give positive feedback, assist verbalization of the source of agitation, assist in setting goals for more pleasant behavior, and seek out staff when agitated.Staff would give the resident as many choices as possible about care and activities.Staff would monitor, document, and report as needed any signs or symptoms of the resident posing a danger to herself or others.R1's EHR Prog Note tab documented the following notes:On 01/18/26 at 02:57 AM, a Weekly Nurses Note documented R1 would transfer herself into other residents' beds and had attempted to disrobe in common areas. She approached male residents with sexually driven remarks; staff were usually able to redirect R1.On 01/23/26 at 03:12 PM, an Alert Note documented R1 had a socially inappropriate behavior; however, on assessment, R1 was smiling and self-propelling up the hallway with no behaviors displayed.On 01/30/26 at 12:12 PM, a General Notes documented R1 was found in R2's (a cognitively intact male resident) (continued on next page)

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 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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NAME OF PROVIDER OR SUPPLIER Diversicare of Hutchinson		STREET ADDRESS, CITY, STATE, ZIP CODE 1202 E 23rd Avenue Hutchinson, KS 67502	

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	room with the door closed. R1 sat in her wheelchair in front of R2, who was in his wheelchair. R1's pants were down, and the male resident was touching R1's peri-area (area of the body around the genitals). Staff separated the residents, redressed R1, and removed her from the male resident's room. Staff provided frequent visual checks to keep the residents separated.R1's Care Plan, revised on 02/10/26, documented R1 sometimes demonstrated sexually inappropriate behaviors such as inappropriate touching or sexual comments, and provided the following interventions revised on 02/04/26:Staff would quietly attempt to redirect R1 if she displayed inappropriate behavior and remind R1 that the behavior was not appropriate.Staff would treat R1 with dignity and respect regardless of any behaviors. Staff would help R1 avoid situations or people that tend to trigger the behaviors.An intervention revised on 02/10/26 directed staff to offer R1 something she liked as a diversion such as baby dolls to hold, revised on 02/10/26.R1's EHR Prog Note tab documented the following notes:On 02/02/26 at 10:31 AM, a General Notes documented R1 was monitored through the weekend and continued to seek male companionship and stated she wanted a man, but was easily redirected into different conversation topics.On 02/15/26 at 01:58 AM, a Weekly Nurses Note documented R1 transferred herself into another resident's bed and attempted to disrobe in common areas. R1 also attempted to approach male residents with sexually driven remarks.On 02/19/26 at 02:35 AM, a General Notes documented a Certified Nurse Aide (CNA) alerted the nurse that R1 was in a common room on a couch and verbalized she was horny to another resident and his family members. Staff removed R1 from the situation and apologized to the male resident and his family.On 02/19/26 at 07:27 PM, a General Notes documented R1 was agitated and combative with staff. She went into other residents' rooms, attempted to take other residents' belongings, but was redirected for two to three minutes with each occurrence. Staff documented R1 said she was looking for a man and approached a male resident and asked him to go to her room. Staff documented R1 was informed the male peer was married and her behavior was inappropriate; R1 continued to yell at staff and was unable to be consoled despite pharmacological and nonpharmacological interventions.On 02/19/26 at 07:35 PM, a General Notes documented R1 was combative with staff and went into other residents' rooms and could not be redirected. R1 required one-on-one observation.On 02/19/26 at 09:48 PM, a General Notes documented R1 was verbally inappropriate with sexually explicit language to staff. Staff documented that one-on-one observation was resumed.On 02/24/26 at 12:53 AM, a General Notes documented R1 saw a male resident coming down the hallway and started to lift her shirt to expose her breasts to him. R1 became angry with the staff when they redirected her and assisted her with placing clothing in appropriate positions. Staff quoted R1 saying, I need a man. Staff provided R1 with food and drink and took her to the bathroom, after which she sat on the couch and fell asleep.On 02/24/26 at 04:20 PM, Administrative Staff B provided a printed copy of Behavior Monitoring and Interventions Report, dated 11/01/25 to 02/24/26, that documented inappropriate behaviors, which included but were not limited to entering into other residents' rooms and/or public sexual acts on 12/16/25, 12/30/25, 01/02/26, 01/04/26, 01/22/26, 01/30/26, 02/12/26, 02/14/26, and 02/19/26.On 02/24/26 at 12:35 PM, staff propelled R1 in her wheelchair.On 02/24/26 at 12:35 PM, an interview with R1 could not be completed due to R1's incomprehensible speech.On 02/24/26 at 10:23 AM, in an interview with Administrative Staff A and Administrative Nurse D via telephone, Administrative Staff A revealed R1 had vocalized several times, since her admission to the facility in 09/2025, that she had been married seven times. Administrative Staff A revealed R1 had been pointing out and gravitating towards males since her admission. R1 had only recently been seeking the attention of male residents.On 02/24/26 at 02:05 PM, Certified Medication Aide (CMA) R stated the only training she had received related to residents with dementia who expressed sexual desires was to let one of the nurses or a member of (continued on next page)

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