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	01/30/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 26768 The facility had a census of 70 residents. Based on observation and interview, the facility failed to ensure a clean, safe, homelike environment for the residents who ate in the dining room and the residents who resided on two of the four resident halls. Findings included: - On 01/30/25 at 08:55 AM, observation during a tour of the facility revealed the following: The dining room floor had a broken tile with a missing piece, approximately five by six inches. The dining room exit to the east had missing door trim, and the foam insulation was visible. The dining room wall behind the ice machines had a hole, approximately one foot by two and a half feet, with the inside wall and pipes visible. The northwest resident hall had numerous damaged or ill-fitting ceiling tiles. The northeast resident hall had numerous damaged or stained ceiling tiles. The northeast hall shower room had a framed hole in the wall, approximately 15 by 15 inches, with the pipes and inner wall visible. On 01/30/25 from 08:55 to 09:05 AM, Administrative Staff A verified the findings and stated the facility had not developed plans to repair the maintenance issues observed. The facility's Room Audit policy, dated 09/01/2014, stated damaged drywall, furniture, or nonfunctioning equipment should be noted, and a work order created and addressed to ensure a homelike standard that meets acceptable standards. The facility failed to ensure a clean, safe, homelike environment for the residents who ate in the dining room and the residents who resided on two of the four resident halls.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634 The facility identified a census of 71 residents. The sample included 18 residents, with five residents reviewed for falls and accidents. Based on observation, record review, and interviews, the facility failed to implement grip strips in front of Resident (R) 20's toilet and failed to implement anti-rollbacks on his wheelchair. This deficient practice placed R20 at risk for future preventable falls. Findings Include: - R20's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of hyperlipidemia (condition of elevated blood lipid levels), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), hypertension (high blood pressure), anemia (an inadequate number of healthy red blood cells to carry adequate oxygen to body tissues), overactive bladder, dementia (a progressive mental disorder characterized by failing memory and confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), dementia (a progressive mental disorder characterized by failing memory and confusion), psychosis (any major mental disorder characterized by gross impairment in reality perception), and mood disorder (category of mental health problems, feelings of sadness, helplessness, guilt, and wanting to die were more intense and persistent than what may normally be felt from time to time). The Quarterly Minimum Data Set (MDS) for R20 dated 01/15/24 recorded a Brief Interview for Mental Status (BIMS) score of seven which indicated severely impaired cognition. The MDS documented R20 had one fall since admission. The MDS documented R20 had an impairment to one side of his body. The MDS documented R20 needed substantial to maximum assistance with putting on and taking off shoes. The MDS documented R20 needed set up and clean up for oral hygiene and eating. The Significant Change (MDS) for R20 dated 10/15/24 recorded a BIMS score of four, which indicated severely impaired cognition. The MDS documented R20 had a fall with an injury since admission. The MDS documented R20 was impaired on one side of his body. The MDS documented R20 needed substantial to maximum assistance with putting on and taking off shoes. The MDS documented R20 needed set up and clean up for oral hygiene and eating. R20's Falls Care Area assessment dated [DATE] documented R20 had a fall with injury, and staff would implement fall precautions. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R20's Care Plan dated 07/30/24 documented R20 had a history of falls, and staff were to encourage R20 to participate in activities that promote exercise and physical activity for strengthening and improved mobility. The nursing staff was to encourage R20 to be cautious and slow when changing elevations to ensure proper circulation to avoid dizziness or disruption in his gait, and staff were to offer toileting every two hours. R20's plan of care documented on 07/30/24 R20 had a fall in his room after tripping over his wheelchair pedals during an attempted self-transfer. R20 did not call for staff assistance, and the intervention was to remove the pedals from R20's wheelchair. R20's plan of care dated 10/13/24 documented a fall with no apparent acute injury, the intervention was that maintenance was to be informed to place grip strips in front of R20's toilet. On 01/01/2025, a documented non-injury falls in his room, and the intervention was that therapy was to evaluate the need for anti-rollback locks to R20's wheelchair dated 01/19/25. On 01/29/24 at 08:30 AM, R20 lay in his bed asleep, with his wheelchair next to his bed. R20 did not have grip strips in front of his toilet, and his wheelchair did not have anti-roll backs on his wheelchair. On 01/130/24 at 10:22 AM, R20 lay in his bed asleep, with his wheelchair next to his bed. R20 did not have grip strips in front of his toilet, and his wheelchair did not have anti-roll backs on his wheelchair. On 01/30/24 at 08:32 AM, Certified Nurse's Aide (CNA) M stated the charge nurse, or the morning meeting team implemented fall interventions. She stated all nursing staff have access to each resident's care plan. On 01/30/24 at 08:40 AM Licensed Nurse (LN) G stated all nursing have access to the resident's care plan, she stated the updated care plans are done by the director of nursing, and nursing staff are updated on what interventions were put in place for falls. On 01/30/24 at 09:13 PM, Administrative Nurse D stated the management team looked over the interventions put in place by nursing. Administrative Nurse D stated she was responsible for following up and ensuring the interventions were put in place had been done. The facility's Fall policy was undated and documented the patient was physically assessed for injuries, and medical attention was rendered as needed. The physician and resident's representative were notified of the fall. A fall huddle was called to investigate circumstances around the fall. The risk event was initiated to capture a detailed description of the event and vital signs, with witness statements and notification of the physician and resident's representative. The risk event prompts the completion of the nurse progress notes and the post-fall analysis (PFA). The post-fall analysis (PFA) was completed to develop all appropriate interventions, record the care plan, review, record notification of caregivers of the new intervention, and documentation of the interdisciplinary team (IDT) decision-making process to prevent future falls. The facility failed to implement grip strips in front of R20's toilet and failed to implement anti-rollbacks on his wheelchair. This deficient practice placed R20 at risk for future preventable falls.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634 The facility identified a census of 71 residents. The sample included 18 residents, with three residents reviewed for trauma-informed care (treatment or care directed to prevent re-experiencing or reducing the effects of traumatic events). Based on observation, record review, and interviews, the facility failed to identify trauma-based triggers related to Resident (R) 7 and R62 posttraumatic stress disorder (PTSD - a mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress) and failed to implement individualized interventions to prevent re-traumatization. These deficient practices placed R7 at risk for decreased psychosocial well-being and ineffective treatment. Findings included: - R7's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of posttraumatic stress disorder, lupus (an autoimmune disease that makes the immune system damage organs and tissue throughout the body), altered mental status, rheumatoid arthritis (chronic inflammatory disease that affects joints and other organ systems), chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), hypertension (high blood pressure), edema (swelling resulting from an excessive accumulation of fluid in the body tissues), diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and asthma (a disorder of narrowed airways that causes wheezing and shortness of breath). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R7 had no behaviors during the observation period. The MDS documented R7 had received antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) drug and antidepressant (a class of medications used to treat mood disorders) medication during the observation period. The Quarterly MDS dated [DATE] documented a BIMS score of 15, which indicated intact cognition. The MDS documented that R7 had no behaviors during the observation period. The MDS documented R7 had received antipsychotic medication and antidepressant medication during the observation period. R7's Psychotropic Drug Use Care Area Assessment (CAA) dated 12/03/24 triggered secondary to the use of psychotropic medication to manage psychiatric illness/condition. A licensed nurse monitors for side effects every shift, and the physician was to be notified of any abnormal findings. A pharmacist consultant would review R7's medications monthly, and the physician would review medications with each visit. Contributing factors include the current history of depression, bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods), mood disorder, and PTSD. Risk factors include increased falls, impaired balance, and potential for adverse effects of medication. R7's care plan would be reviewed to monitor the effectiveness of psychotropic medication and any adverse effects of medication. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R7's Care Plan, revised on 09/19/22, documented R7 had a potential psychosocial well-being problem related to a history of depression and PTSD and a disinterest in her favorite activities. Staff were to allow R7 time to answer questions and to verbalize feelings, perceptions, and fears as indicated. Nursing staff were to consult with the pastoral care, social services, and psychological services. R7's plan of care documented if a conflict arises, staff were to remove R7 to a calm and safe environment and allow R7 to vent and share her feelings. R7's plan of care documented staff was to document R7's feelings and provide opportunities for R7 and her family to participate in her care. R7's 'Care Plan lacked documentation of trauma-based triggers and individualized interventions for R7's diagnosis of PTSD. On 01/29/25 at 08:06 AM, R7 was wheeling herself around the halls with her dog, visiting with peers. On 01/29/25 at 09:13 AM, Administrative Nurse E, the MDS coordinator, stated R7 was very private and did not talk about her childhood. Administrative Nurse G stated she would call her resident representative and talk with her about triggers and what staff would need to know to consult R7. On 01/30/25 at 08:32 AM, Certified Medication Aide (CMA) M stated she was unsure if R7 had PTSD. CMA M stated she did not know what R7's triggers were and was unsure what she would do. CMA M stated she would probably call her supervisor. On 01/30/25 at 08:40 AM, Licensed Nurse (LN) G stated she did not know R7 had PTSD as she had not been at the facility very long. LN G stated she would look in her care plan and see what triggers R7 and what she needed to do. On 01/30/25 at 02:33 PM, Administrative Nurse D stated the care plan should be individualized, and the facility would talk to R7 and her family about behaviors or triggers that staff would need to be aware of. Administrative Nurse D stated the facility would update R7's care plan. The facility's Trauma Based Care policy undated documented trauma survivors have unique care needs that must be incorporated into the plan of care. Team members must understand types of traumatic experiences and their impact on residents. Recognition of different kinds of trauma that impact our residents and identifying triggers that may cause negative effects, along with care strategies that can eliminate these triggers and prevent re-traumatization is vital to providing care for our patients. The facility failed to identify trauma-based triggers related to R7's history of trauma and implement individualized interventions to prevent re-traumatization. These deficient practices placed R7 at risk for decreased psychosocial well-being and ineffective treatment. 26768 - Resident (R) 62's Electronic Medical Record documented diagnoses of Alzheimer's Disease (progressive mental deterioration characterized by confusion and memory failure), post-traumatic stress disorder (PTSD - a mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and insomnia (inability to sleep). (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Quarterly Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of five, indicating severely impaired cognition. The MDS documented R62 had no behaviors, required set up with eating, and partial to maximum staff assistance with activities of daily living. R62 was independent with bed mobility and required substantial staff assistance for transfers. The MDS documented R62 used a wanderguard alarm daily and no bed rails. R62's Care Plan, dated 11/30/24, directed staff to encourage ongoing family involvement and invite the resident's family to attend special events, activities, and meals. The care plan directed staff to establish and record the resident's prior level of activity involvement and interests by talking with the resident, caregivers, and family on admission and, as necessary, initiated 11/30/24. R62's care plan directed staff to use R62's preferred name. Identify yourself at each interaction. The care plan stated R62 had a diagnosis of Post-Traumatic Stress Disorder related to a history of witnessing a Traumatic Event (military service) and directed staff to allow the patient time to complete tasks without feeling rushed or hurried and provide a calm and reassuring environment, initiated 11/30/2024. The Fall Note, dated 10/25/24 at 09:55 AM, documented R62 was found on the floor by his nurse. He was wrapped up in his blankets, and the bed was in the low position. R62 had a dry brief on, the call light was not activated, and he denied pain or discomfort. R62 stated he was trying to move his bed. The Fall Follow-up Note, dated 10/25/24 at 11:32 PM, documented R62 was alert to self only with near-continuous confusion regarding the situation and exhibited paranoid and impulsive behaviors at times. R62 remained a high-fall risk due to multiple attempts to stand, transfer, or toilet self. R62 could become difficult to redirect and exhibited instances of agitation and voicing refusal of care. R62 required assist of one staff with transfers and his gait is very unsteady and uncoordinated. 01/28/25 at 01:02 PM R62 sat in a chair for an hour prior to lunch across from the nurse's station with head down, not looking around. On 01/28/25 at 03:30 PM, R62 sat in his wheelchair across from the nurse's station, watching people with a flat affect (absence or near absence of emotional response to a situation that would normally elicit emotion). On 01/29/25 at 01:02 PM, Certified Nurse Aide (CNA) N stated she had not been told anything specific to watch for regarding R62's PTSD. On 01/29/25 at 01:20 PM, CNA O stated she had not been made aware of R62's PTSD and did not know what triggers to avoid. On 01/29/25 at 04:02 PM, Administrative Nurse E stated the resident's wife had not reported any issues regarding PTSD, and the facility had not pursued information regarding what might trigger an episode. She verified the care plan lacked information on what triggers to avoid a PTSD episode. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's undated Trauma Informed Care policy stated trauma survivors had unique care needs that must be incorporated into the plan of care. Team member must understand types of traumatic experiences and their impact on residents. Recognition of different kinds of trauma that impact our residents and identifying triggers that may cause negative effects, along with care strategies that can eliminate these triggers and prevent re-traumatization was vital to providing care for the residents. The facility failed to ensure care and services for R62 were delivered using approaches that address the needs of trauma survivors by minimizing triggers and/or re-traumatization, placing R62 at risk for re-traumatization.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27168 The facility had a census of 70 residents. The sample included 18 residents, with two reviewed for side rails. Based on observation, record review, and interview, the facility failed to assess the actual rail being used to assure safety for Resident (R) 8 and R62. This deficient practice placed R8 at risk for preventable injury. Findings included: - The Electronic Medical Record (EMR) for R2's diagnoses included Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure, bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods), cerebrovascular accident (CVA -stroke- sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), and osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain). R8's Annual Minimum Data Set (MDS), dated [DATE], recorded the resident had a Brief Interview for Mental Status (BIMS) score of four, indicating severe cognitive impairment. The MDS documented R8 required substantial assistance with mobility-rolling left to right. The MDS lacked documentation the resident had siderails. R8's medical record recorded a Side Rail Assessment completed on 03/11/24 for assist rails used by the resident, documenting the resident had poor safety awareness due to decreased cognitive function. The side rail safety did not check that the side rails had been measured, the gaps between the rails themselves, or the gaps between the side rails and the mattress were conducive to resident safety as based on this individual resident. The assessment documented the side rail was not a restraint and would be utilized to enable the resident to attain or maintain her highest practicable level. On 01/28/25 at 02:30 PM, a one-half side rail was on the left side of R8's bed. The side rail on the top left side with openings approximately 3.75 inches by 32.0 inches. On 01/28/24 at 04:50 PM, Administrative Staff A and Administrative Nurse E verified the staff should measure the bed rail gaps for safety quarterly or with a significant change in the resident's status, and R8's bed rails had too large of openings. Upon request, the facility failed to provide a side rail policy. The facility failed to adequately assess R8'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 R8's bed. This deficient practice placed R8 at risk for preventable entrapment, accident, or injury. 26768 (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Resident (R) 62's Electronic Medical Record documented diagnoses of Alzheimer's Disease (progressive mental deterioration characterized by confusion and memory failure), post-traumatic stress disorder (PTSD - a mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and insomnia (inability to sleep). The Quarterly Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of five, indicating severely impaired cognition. The MDS documented R62 had no behaviors, required set up with eating, and partial to maximum staff assistance with activities of daily living. R62 was independent with bed mobility and required substantial staff assistance for transfers. The MDS documented R62 used a wanderguard alarm daily and no bed rails. R62's Care Plan, dated 11/30/24, lacked any information regarding the use of bed rails. The Fall Note, dated 10/25/24 at 09:55 AM, documented R62 was found on the floor by his nurse. He was wrapped up in his blankets, and the bed was in the low position. R62 stated he was trying to move his bed. The Fall Follow-up Note, dated 10/25/24 at 11:32 PM, documented R62 was alert to self only with near-continuous confusion regarding the situation and exhibited paranoid and impulsive behaviors at times. R62 remained a high-fall risk due to multiple attempts to stand, transfer, or toilet self. R62 could become difficult to redirect and exhibited instances of agitation and voicing refusal of cares. R62 required the assistance of one staff with transfers, and his gait is very unsteady and uncoordinated. The Side Rail Assessment, dated 12/24/24, was incomplete, and the assessment for measuring gaps was blank. 01/28/25 at 01:02 PM, R62 sat in a chair for an hour prior to lunch across from the nurse's station with his head down, not looking around. On 01/28/25 at 04:20 PM, R62's bedside rails were up on both sides of the bed and had approximately 4.5 by 24-inch gaps between the bars. On 01/29/25 at 04:45 PM, Administrative Nurse D verified staff should have measured the side rails gaps and assessed the side rails quarterly. She verified the width of the gap was greater than 4 and 3/4 inches. On 01/29/25 at 04:50 PM, Administrative Staff A stated staff were to measure bed rail gaps for safety at least quarterly. Upon request, the facility failed to provide a bed rail policy. The facility failed to assess the R62's risk of entrapment by measuring the gaps between the bars for safety. This deficient practice placed R62 at risk for unsafe use of bed rails and preventable entrapment.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27168 The facility had a census of 70 residents. The sample included 18 residents, with five reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to ensure the Consultant Pharmacist identified and reported an inappropriate indication for the use of an antipsychotic medication (a class of medications used to treat any major mental disorder characterized by a gross impairment in reality testing and other mental emotional conditions) for one of five sampled residents, Resident (R) 5. This deficient practice placed the resident at risk for unnecessary medications and related side effects. Findings included: - The Electronic Medical Record (EMR) for R5 documented diagnoses of dementia with agitation (a progressive mental disorder characterized by failing memory and confusion), Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), and cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain). The Quarterly Minimum Data Set (MDS), dated [DATE], documented R5 had moderately impaired cognition. R5 was dependent upon staff for toileting, lower body dressing, mobility, and transfers. R5 was always incontinent of bladder and frequently incontinent of bowel. R5 received an antipsychotic medication. R5's Care Plan, dated 10/29/24, directed staff to administer medication as ordered and observe for potential drug-related complications associated with the use of psychotropic medication Rexaulti. The 11/07/24 updated care plan directed staff to observe for side effects and report to the physician sedation, drowsiness, dry mouth, constipation, blurred vision, weight gain, edema, sweating, loss of appetite, and urinary retention. The care plan documented the medication was used for dementia with agitation, and the facility would obtain consent from the resident/responsible party for the use of psychotropic medications. The care plan documented the facility would consult the pharmacy as needed. The Physician's Order, dated 08/21/24, directed staff to administer Rexaulti, 0.5 mg, by mouth, one time per day, for dementia with agitation. R5's EMR lacked evidence of a physician-documented rationale, which included the risks versus benefits for R5's Rexaulti. The Pharmacy Consult reviews on 09/14/24, 10/19/24, 11/20/24, 12/16/24, and 01/29/25 lacked a recommendation for an appropriate indication for use. R5's clinical record lacked evidence of documented physician rationale, which included the multiple unsuccessful attempts for nonpharmacological symptom management and risk versus benefit for the continued use of R5's Rexaulti. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/29/25 at 08:15 AM, R5 sat at the dining room table, nicely groomed and dressed, eating breakfast. Licensed Nurse (LN) I administered R5's morning medications, including his Rexaulti. On 01/29/25 at 09:00 AM, Administrative Nurse D verified the inappropriate diagnosis of dementia with agitation for R5's use of the Rexaulti medication. The facility's Medication Regimen Review policy, dated 11/28/2016, documented the facility would identify irregularities that require urgent action, that included timely notification, and what, if any, action was taken to address the issues. The policy documented if the Consulting Pharmacist identified an urgent medication irregularity during the medication regimen review that required immediate action, the consulting pharmacist would notify the nurse and request the center contact the attending physician to communicate the issue and obtain direction or new orders. The policy documented that if the attending physician decided to make no changes in the medication, the attending physician would document the rationale in the resident's health record. The facility failed to ensure the Consultant Pharmacist identified and reported to the facility, DON, medical director, and physician the inappropriate indication for R5's use of Rexaulti. This deficient practice placed the resident at risk for inappropriate use of an antipsychotic medication.

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	01/30/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 26768 The facility had a census of 70 residents. Based on observation, interview, and record review, the facility failed to dispose of expired medications in a timely manner. This deficient practice placed residents at risk to receive ineffective medication. Findings included: - On 01/28/25 at 01:35 PM, observation in the facility's only medication room revealed a bottle of 325 milligrams (MG) aspirin tablets with an expiration date of 08/2024 and a bottle of GeriMox (antacid medication), expired 11/2024. On 01/28/25 at 01:35 PM, Licensed Nurse (LN) J verified the expired drugs should have been disposed of. The facility's Medication Storage in the Facility policy, dated April 2020, stated drugs dispensed in the manufacturer's original container would be labeled with the manufacturer's expiration date. All expired medication would be removed from the active supply and destroyed in the facility. No expired medications would be administered to a resident. The facility failed to dispose of expired medications in a timely manner. This deficient practice placed residents at risk to receive ineffective medication.