STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175133	A. Building B. Wing	06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Diversicare of Haysville	215 N Lamar Avenue Haysville, KS 67060

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 1, R2, R3, R4, R5, R6, R7, R8, and R9 remained free from misappropriation when facility staff diverted 187 hydrocodone, Oxycodone, and/or Percocet (potent semi-synthetic opioid analgesics and antitussive used to treat severe pain) between 02/01/2025 to 10/30/2025. Findings included:- Review of the Electronic Medical Record (EMR) revealed the following: 1. The EMR for R1 documented diagnoses of central cord syndrome (an incomplete spinal cord injury characterized by disproportionately more weakness in the arms and hands than in the legs), sprain of ligaments of cervical spine, spinal stenosis (degenerative condition of the spine that could cause weakness and loss of use of extremities), fusion of spine, and chronic pain. R1's EMR had a Physician Order dated 08/21/2025 for Hydrocodone, 5 milligrams (MG) 1.5 tablet by mouth every four hours as needed for severe pain, with a stop date of 09/08/2025. R1's Medication Administration Record (MAR) for August and September 2025 documented that pain was assessed, and the pain medication had been provided. 2. The EMR for R2 documented diagnoses of fracture of the lower end of right radius, motorcycle driver injured in collision with car, pick-up truck or van in traffic accident, and gout (inflammation of the joints). R2's EMR had a Physician Order dated 08/21/2025, with a stop date of 08/21/2025, for Oxycodone, 15 mg, one tablet by mouth every four hours as needed for pain; another order, with a start date of 08/21/2025 and stop date of 08/29/2025, was for Oxycodone, 15 mg, one tablet every four hours as needed for pain and one tablet by mouth one time daily for pain. R2's MAR for August 2025 documented that pain was assessed, and the pain medication had been provided. 3. The EMR for R3 documented diagnoses of chronic pain. R3's EMR had a Physician Order dated 09/12/2025, with a stop date of 10/01/2025, for Hydrocodone-Acetaminophen, 5-325 mg, one tablet by mouth every four hours as needed for pain. Another order, dated 10/01/2025 with a stop date of 11/11/2025, was for Hydrocodone-Acetaminophen, 5-325 mg, one tablet by mouth every four hours as needed for pain and one tablet by mouth twice daily for pain. R3's MAR for August 2025 documented that pain was assessed, and the pain medication had been provided. 4. The EMR for R4 documented diagnoses of pain in left shoulder, polyneuropathy (a neurological condition characterized by the simultaneous damage to multiple peripheral nerves throughout the body), chronic pain, pain in left knee, and fracture of upper end of left humerus. R4's EMR had a Physician Order dated 05/27/2025, with a stop date of 09/26/2025, for Hydrocodone-Acetaminophen 7.5-325 mg, one tablet by mouth four times daily for chronic pain. Another order, dated 09/30/2025 with a stop date of 10/30/2025, was for Hydrocodone-Acetaminophen 7.5-325 mg, one tablet by mouth four times daily for pain. R4's MAR for August-September-October 2025 documented that pain was assessed, and the pain medication had been provided. 5. The EMR for R5 documented diagnoses of chronic pain, and chest pain. R5's EMR had a Physician Order dated 09/16/2025, with a stop date of 09/17/2025, for Hydrocodone-Acetaminophen 5-325 mg, one tablet by mouth every four hours as needed for pain. Another order, dated 09/17/2025 with a stop date of 10/07/2025, was for Hydrocodone-Acetaminophen 5-325 mg, one tablet by mouth every four hours as needed for pain, not to exceed 3 grams (GM) acetaminophen from all sources in 24 hours. R5's MAR for September-October 2025 documented that pain was assessed, and the pain medication had been (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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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	provided. 6. The EMR for R6 documented diagnoses of spinal stenosis, neurogenic claudication (pain, numbness, tingling, or weakness in the lower back, buttocks, and legs that are triggered by standing or walking and relieved by sitting or leaning forward), chronic pain, polyneuropathy, rheumatoid arthritis (chronic inflammatory disease that affects joints and other organ systems). R6's EMR had a Physician Order dated 06/20/2025, with a stop date of 10/10/2025, for Percocet 5-325 mg, one tablet by mouth every six hours as needed for chronic pain, and one tablet daily for chronic pain. Another order, dated 10/10/2025 with a stop date of 12/13/2025, was for Percocet 5-325 mg, one tablet by mouth every four hours as needed for chronic pain, and one tablet daily for chronic pain. R6's MAR for August-September-October 2025 documented that pain was assessed, and the pain medication had been provided. 7. The EMR for R7 documented diagnoses of gout, and chronic pain. R7's EMR had a Physician Order dated 11/20/2024 for Hydrocodone-Acetaminophen 7.5-325 mg, one tablet by mouth every six hours as needed for pain. R7's MAR for August-September-October 2025 documented that pain was assessed, and the pain medication had been provided. 8. The EMR for R8 documented diagnoses of chronic pain, polyneuropathy, and osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain). R8's EMR had a Physician Order dated 04/15/2025, with a stop date of 05/26/2026, for Hydrocodone-Acetaminophen 7.5-325 mg, one tablet by mouth every six hours as needed for pain. R8's MAR for August-September-October 2025 documented that pain was assessed, and the pain medication had been provided. LN I's Notarized Witness Statement, dated 10/2025, documented that she had taken the narcotics paper for R8 and placed it in the back of the narcotics book and left it there for another nurse to verify and remove it. She left the previous night around 11:38 PM and did not remove the paper or have another nurse review it because her shift had ended at 10:00 PM and she was in hurry to get her kids back to the hotel and sleep because they had school the next day, 10/27/2025. On 10/27/2025 she was told the paper was nowhere to be found. LN I cleaned out the drawers at the nurse's station, her office, and by the fax machine on hall five and the paper was not found by her or the other nurses that helped her look. LN H's Notarized Witness Statement, dated 10/29/2026, documented that she did not remember co-signing R8's 10/10/2025 narcotic sheet for LN I. LN J's Notarized Witness Statement, dated 10/27/2025, documented when she and another staff were counting R9 asked for pain medication. R9 was given medication and when LN J did the count she noticed R9 had a card with five Hydrocodone and a card with 27 hydrocodone, the next morning another staff could not find the narcotic sheet for R9 that was removed by LN I at 11:00 PM on 10/26/2025. LN K's Notarized Witness Statement, dated 10/29/2025, documented that she did not remember co-signing the controlled substance reconciliation record as witness for the nurse she was asked about. LN K also documented that she did not recognize the handwriting of the initials she was asked if were her's, and she did not work some of the dates she was asked about. The facility's investigation, dated 11/04/2025, documented on 10/27/2025 one narcotic sheet and one narcotic card were removed from the medication cart on hall five which was signed out by LN I. No narcotic record was turned into medical records for that date. The facility completed an audit from 02/01/2025 to 10/30/2025 and they found 187 opioid tablets missing from 08/22/2025 to 10/27/2025, and LN I was working for the time periods that showed the narcotics missing. The investigation also documented that document falsification also occurred with team member initials on the reconciliation logs when the narcotic logs were removed; three narcotic cards were removed from the reconciliation log without documentation. The investigation documented that LN I had been responsible for the missing narcotics from hall five by falsifying staff initials and removing a narcotic card that was not empty when a new card arrived from the pharmacy. The facility filed a report with the police department on 10/28/2025. The facility then implemented that the empty narcotic card would remain on the cart until medical records or a designee would remove them. They also had the pharmacy send a report of all narcotics that were ordered each week, and the facility cross referenced it. All nurses and medication aides were re-educated on the documentation of recording correctly on the medication log, and the Abuse, Neglect, Misappropriation, Exploitation policy was (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reviewed with all staff. The facility also contacted the human resource department and initiated appropriate action and drug screen against the staff member in question and suspend the staff member on 10/27/2025. They then began the reimbursement process to all residents that were affected. The director of nursing, or designee, then performed narcotic audits three times a week for two weeks, then weekly for four weeks, and then monthly for three months. The results of the on-going audits were then shared at the monthly Quality Assurance and Performance (QAPI) meetings. Observed on 06/16/2026 at 08:28 AM, CMA R went through the hall five medication cart narcotics drawer and counted the narcotics. The narcotics logbook was checked for accuracy for the month of June 2026. the June 2026 Controlled Substance Shift Count Sheet showed a missing signature for the off-going shift on 06/14/2026 at 06:00 AM. oncoming shift, dated 06/15/2026 at 10:00 PM, and off-going shift, dated 06/16/2026 at 06:00 AM. Observed on 06/16/2026 at 09:30 AM, LN H went through the medication room and at that time there were no narcotic drugs in the room. On 06/16/2026 at 08:28 AM, CMA R said that two staff counted the controlled medications every time they changed shifts, and both signed the shift count sheet for verification. She also said that now they leave the empty narcotic card in the cart until the medical records pulled it out with a witness and verified the count. CMA R also said anytime a medication was discontinued, Administrative Nurse D would pull it and the count sheet out and both staff members would sign the sheet. On 06/16/2026 at 08:36 AM, R8 reported she had no uncontrolled pain, staff gave her something any time she needed it for pain. On 06/16/2026 at 09:30 AM, LN H said the CMA left the empty cards in the cart until administrative staff retrieved them. She also said that any discontinued narcotics stayed in the cart and were counted by Administrative Nurse D, and then Administrative Nurse D and the pharmacist destroyed them. On 06/16/2026 at 09:48 AM, R9 reported that her pain level varied and sometimes she would hurt worse than other times. When she asked for a pain pill, staff always got her one right away,. On 06/16/2026 11:03 AM, Administrative Nurse D reported that prior to the diversion, the nurses would remove the empty cards and give the count sheets to medical records. Administrative Nurse D stated she worked day shift in October 2025, one day the CMA had to leave early, so they were counting the narcotics and R9 requested a narcotic. Administrative Nurse D said she popped the narcotic from the card and signed it out, as they counted, Administrative Nurse D realized she signed the wrong sheet and then fixed it. The next morning when Administrative Nurse D was counting the narcotics she noticed that the narcotic sheet she had signed out the medication on the previous day was missing. Administrative Nurse D said she alerted the director of nursing, and they went back and looked at the previous 90 days. She said he nurse that worked the previous night had, several times, not have someone sign with her that a card was empty. Administrative Nurse D said the facility changed the process. On 06/16/2026 at 12:15 PM, Administrative Staff A said that when the diversion occurred the facility immediately began an investigation and once it was completed, the facility contacted the Kansas State Board of Nursing (KSBN) and turned LN I in. The facility policy Abuse, Neglect, Misappropriation, Exploitation Policy, dated January 2019, documented that the purpose was to prohibit and prevent abuse, neglect, exploitation, misappropriation of resident property and to ensure reporting and investigation of alleged violations (to include injuries of unknown source, mistreatment and involuntary seclusion) in accordance with Federal and State Laws. All corrective actions were completed by 11/03/2025, prior to the onsite survey therefore the deficient practice was deemed past noncompliance.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** Based on observation, record review, and interview, the facility failed to accurately identify risks and provide interventions and adequate supervision to prevent an elopement for Resident (R) 1. On 05/16/2026, staff assessed R1's elopement risk during a Health Status Evaluation and inaccurately assessed R1 with the inability to leave the facility unattended therefore no risk was identified. On 05/28/2026 at around 01:50 PM, residents alerted Licensed Nurse (LN) G that R1 was outside on the East side of the building. LN G brought R1 back inside and assisted R1 into dry clothes. The facility was on [NAME] roads with posted speeds up to 35 miles per hour. The area also included other hazards such as a leaning fence with loose boards and nails on the ground. There was densely wooded tree line to the south and west of the facility. The weather at the time was approximately 72 degrees Fahrenheit (F.) with winds up to 15 miles per hour; it was raining at the time. The facility's failure to accurately identify risks and provide adequate supervision placed R1 in immediate jeopardy. Findings included:- The Electronic Medical Record (EMR) for R1 documented diagnoses of dementia, muscle weakness, difficulty walking, unsteadiness on feet, lack of coordination, repeated falls, and cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness). R1's Annual Minimum Data Set (MDS), dated 05/20/2026, documented a Brief Interview for Mental Status (BIMS) score of 10, which indicated moderate cognitive impairment. R1 used a walker for ambulation, was independent with toileting hygiene, and required partial to moderate assistance for bathing. The MDS documented that R1 had two or more falls since admission, re-entry or since the prior assessment; at least one fall resulted in injury. R1's Care Plan, revised on 01/16/2025, documented that she was at risk for falls. The revised intervention dated 09/08/2025 informed staff that R1 ambulated independently with her walker. The intervention dated 01/26/2026 instructed staff to offer R1 assistance with ambulation and to encourage her to use her walker. R1's Care Plan, dated 05/29/2024 and revised 06/08/2026, documented that she had impaired cognitive function/dementia or impaired thought process related to dementia. The related intervention, dated 05/29/2024, instructed staff to monitor, document, and report, as needed, any changes in R1's cognitive function, specifically changes in decision making ability, memory, recall and general awareness, difficulty expressing herself, difficulty understanding others, level of consciousness, and mental status. R1's Care Plan lacked interventions related to R1's wandering or elopement risk. The General Note on 02/24/2026 at 02:03 AM documented R1 was having increased confusion at night and wandered the hall in a shirt and incontinent brief. She had to be redirected and assisted back to her room. The Clinical Health Status Evaluation 1.0-V4-V5, dated 05/16/2026, under Elopement was marked no and therefore the rest of the remaining questions were disregarded. The Weekly Nurse's Note on 05/23/2026 at 01:31 AM documented that R1 had increased confusion at night, she wandered the hallway and required redirection and assistance back to bed. The General Note on 05/28/2026 at 05:05 AM documented that R1 continued to be weak and needed assistance to the bathroom. The General Note on 05/28/2026 at 03:11 PM documented that at approximately 01:20 PM staff observed R1 sitting at a table drinking coffee and watching the rain. At approximately 01:50 PM R1 was observed walking outside with her walker. Staff assisted her to her room and assisted her with changing into dry clothes. Staff assessed her at that time. Staff received a physician's order and a Wanderguard (a bracelet that helps monitor residents who are at risk of wandering) was placed on R1. The Weekly Nursing Note on 05/31/2026 at 06:02 AM documented that R1 was an elopement risk and the Wanderguard was in place. R1 continued to require assistance and her walker due to an unsteady gait. The facility investigation, dated 06/05/2026, documented the elopement protocol was followed when the resident was found, all residents were accounted for, and all Wanderguards were tested. All staff were then re-educated on elopement with a drill. The elopement books were updated (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	with R1's information and each door was checked for functionality. The report also documented that the WanderGaurd system was functioning appropriately, but the front door was found to not be fully latching. A staff member was posted at the door continuously from 02:00 PM until the door was found to be functioning appropriately at 09:49 AM on 05/29/2026. R1 was seen by the provider on 05/29/2026 and determined to have a urinary tract infection. The facility In- Service Training Record, dated 05/28/2026, and completed 05/28/2026, documented staff were trained on the elopement policy and mandatory frequent checks on all residents. The third-party vendor invoice, dated 06/02/2026 with a service date of 05/29/2026, documented that a service technician installed a doorbell system on the front lobby door and everything tested and worked properly. CNA M's undated Facility Witness Statement documented that R1 was walking out of hall four. CNA M stopped R1 and noticed she had her purse. CNA M asked R1 where she was going and R1 said to her car. CNA M told R1 to sit in the recliner before lunch. Once lunch was being served, CNA M walked R1 to the seat, pushed her in and gave her lunch. R1 was eating lunch the last time CNA M saw her. Consultant GG's undated Facility Witness Statement documented that the resident attempted to exit the main door at 01:20 PM. Consultant GG distracted the resident and seated her with a cup of coffee. The resident was not agitated and agreed not to go out due to the rain; she was content to relax and watch the rain. Consultant GG was called away from the conversation to help another resident. LN G's undated Facility Witness Statement documented at approximately 01:20, R1 was sitting at the table in front of the windows drinking a cup of coffee. R1 seemed content to look out the window at the rain. Administrative Staff A's undated Facility Witness Statement documented she held the door open for another resident at 01:15 PM as he returned inside the building. She discussed the weather with him and about letting a family member visit. It was documented that since the door had been held open for too long the alarm sounded. She followed the resident and family member in, and the door latched appropriately. Administrative Staff A stated she then left for lunch and at that time, R1 sat at a nearby table, drank a cup of coffee, and the door functioned appropriately. Observed on 06/15/2026 at 12:35 PM, R1 sat in the dining room drinking liquid and eating lunch with other residents. She had a WanderGuard loosely in place on her right ankle. Observed on 06/15/2026 at 01:30 PM, while exiting the main door, the inner door that goes into the facility had to be forcibly pushed shut as it remained slightly open and did not fully close itself and lock shut. Observed on 06/15/2026 at 01:40 PM, the facility was located one block east of the main thoroughfare that runs north and south through the town with a speed limit of 35 miles-per-hour (mph). The main road, that butted up to the north edge of the facility property had a 20-mph speed limit. The street that ran east and west on the south side of the facility campus and turned intersecting with another street on the east side of the facility had no posted speed limit. There was a privacy fence that separated the facility's front parking lot and an apartment parking lot that was leaning, had several missing boards throughout and there were several loose boards with nails scattered amongst the ground next to the fence. On 06/15/2026 at 12:22 PM, CNA M said residents were identified as wandering if their routines were different from baseline. She said on the day R1 eloped, R1 was down another hall wandering, said her car was in the shop, and she needed to get it. CNA M said she tried to calm her down and told her she had a reservation for lunch. This was at 12:45 PM and she was very focused and insistent about her car. CNA M said the nurse on duty was right there when she was redirecting R1 and she sat R1 down in the common area with the nurse and another nurse. She said the nurse gave her the ok and thumbs up. On 06/15/2026 at 12:27 PM, CNA N said residents were identified as wanderers if they went from room to room, different hall to different hall, if they were confused and if they said they wanted to go home. CNA N said that she was not sure how long R1 had been outside, but she seemed a little off after she was brought back inside. She also said that R1 had been more confused recently. On 06/15/2026 at 12:22 PM, LN G said R1 had been sitting by the main window drinking coffee and watching the rain. About 20 minutes later, other residents said they saw R1 wandering around outside with her walker. She said that R1 had not required any more assistance that day than previous days, and she would often get confused and lost (continued on next page)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, record review, and interview, the facility failed to ensure an accurate reconciliation of controlled medications (substances that have an accepted medical use, and have a potential for abuse, ranging from low to high, and may also lead to physical or psychological dependence) was completed. Findings included:- A facility reported incident, dated 10/27/2025, documented that one narcotic sheet was missing from the hall five medication cart. The facility then performed a medication audit that covered 02/01/2025 through 10/30/2025. The facility discovered that from 08/22/2025 to 10/27/2025 a total of 187 opioid tablets was missing from the hall five medication cart. The facility immediately implemented corrective actions that included the empty card and control sheet would remain on the cart until medical records or a designee removed them, and all licensed nurses (LN) and certified medication aides (CMA) were re-educated on documentation of recording correctly on the medication log. On 06/16/2026 at 11:30 AM, a review of the June 2026 Controlled Substance Shift Count Sheet showed a missing signature for the off-going shift on 06/14/2026 at 06:00 AM. oncoming shift, dated 06/15/2026 at 10:00 PM, and off-going shift, dated 06/16/2026 at 06:00 AM. On 06/16/2026 at 08:28 AM, CMA R said that two staff counted the controlled medications every time they changed shifts, and both signed the shift count sheet for verification. On 06/16/2026 at 12:16 PM, Administrative Nurse D said she received the email on 06/15/2026 about the staff not signing the count sheet on 06/14/2026. She said she thought it had been taken care of, so she had done nothing about it. Administrative Nurse D then said she had received an email on 06/16/2026 about the off-going nurse's signature missing on 06/14/2026 at 06:00 AM, and the oncoming nurse for 06/15/2026 at 10:00 PM, and off going nurse on 06/16/26 at 06:00 AM. She then said that when this occurred, she would notify the nurse that they needed to come back and verify the count and sign the sheet. The facility policy Controlled Substance Guideline: Chapter 4 Change of shift reconciliation documented that two licensed nurses (or one licensed nurse and one certified medication technician or two certified medication technicians - where allowed by law) - typically the nurse/medication tech arriving on duty and the nurse/medication tech departing from duty; are required to conduct the reconciliation (i.e. Change of Shift Count) of patient specific controlled substances and sign a signature log attesting to the completion and accuracy of the count.