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	03/12/2025

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

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 45668 The facility identified a census of 81 residents. The sample included 21 residents, with five residents reviewed for dignity. Based on observation, interview, and record review, the facility failed to provide a dignified care environment for Resident (R) 9, R14, R27, and R130. This deficient practice placed the residents at risk for impaired dignity and quality of life. Findings Included: - On 03/10/24 at 09:10 AM, R9 (a severely cognitively impaired resident) was assisted by an unidentified staff member in her room. R9 sat on the side of her bed in her room. R9's bedside table was positioned in front of her with her breakfast. R9 had only underwear on her lower half. R9 fell asleep as she sat on the side of her bed with her head against the wall. Her leg and groin area were left exposed. On 03/10/25 at 10:17 AM, R14 (a severely cognitively impaired resident) sat in his bed with his door fully open. R14 only had a sheet covering his groin area as staff and other residents passed his room. On 03/11/25 at 09:08 AM, R27 (a severely cognitively impaired resident) sat in her Broda chair (specialized wheelchair with the ability to tilt and recline) at the window table in the dining room. R27 recevied feeding assistance for her breakfast meal. The staff member stood the entire time while feeding her breakfast. On 03/11/25 at 09:32 AM, R130 (a physically and cognitively impaired resident dependent on all assistance) lay in her bed facing the door. R130 wore a gown but her entire upper right side up to her chest was exposed while her bed faced the door. On 03/12/25 at 12:38 PM, Certified Medication Aide (CMA) R stated staff were expected to cover up the residents to prevent exposure and possible embarrassment. She stated staff were expected to sit next to the residents while providing feeding assistance. On 03/12/25 at 01:04 PM, Licensed Nurse G stated some residents would prefer not to wear pants or clothing, but the facility was responsible for ensuring the residents were dressed and preventing possible exposure to themselves or others. She stated staff should never stand while providing feeding assistance to the residents. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/12/24 at 01:30 PM, Administrative Nurse D stated staff were expected to provide dignified care to each resident. She stated staff were to sit next to residents while assistance was provided. She stated staff were expected to monitor each resident to prevent the resident from being exposed. The facility's Resident Rights and Quality of Life policy revised 05/2012 indicated the facility was to ensure a dignified existence for all residents. The policy noted the facility would ensure a clean, comfortable, and safe environment for each resident. The facility failed to provide a dignified care environment for R9, R14, R27, and R130. This deficient practice placed the residents at risk for impaired dignity and quality of life.

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037 The facility identified a census of 81 residents. The sample included 21 residents, with one resident reviewed for self-administration of medication. Based on observation, record review, and interviews, the facility failed to ensure safe and appropriate self-administration of medication for Resident (R) 22. This deficient practice placed R22 at risk for unnecessary medication side effects and self-administration errors. Findings included: - R22's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of blindness in one eye, paraparesis (partial paralysis, usually affecting only the lower extremities), need for assistance with personal care, muscle weakness, and cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness). The Admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R22 was dependent on staff assistance for transfers. The MDS documented R22 had received 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 R22 required substantial to maximum assistance with upper body dressing and was dependent on staff assistance with bed mobility. R22's Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 06/08/24 documented she required assistance with all daily cares and most tasks required the assistance of two staff members. R22's Care Plan dated 09/05/24 documented staff would administer her medications as ordered. Review of R22's EMR under the Orders tab lacked any order for the self-administration of medication. Review of R22's EMR lacked an assessment related to the self-administration of medication. On 03/10/25 at 08:49 AM, R22 laid on her bed with the head of her bed elevated and her bedside table over the bed. R22 stated she was waiting for breakfast and a paper medication cup with multiple pills sat on top of her water pitcher on the bedside table. On 03/11/25 at 09:48 AM, R22 laid asleep with her bedside table across the bed in front of her. On R22's water pitcher sat a paper medication cup with multiple medications in the cup. On 03/12/25 at 12:17 PM, Certified Medication Aide (CMA) R stated a resident would require a physician order for self-medication administration after the nurse had performed an assessment to ensure they were safe to administer their own medications, (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/12/25 at 12:42 PM, Licensed Nurse (LN) G stated that R22 did not have an order to self-administer her medications and the medication should not be left on her bedside table. On 03/12/25 at 01:29 PM, Administrative Nurse D stated that R22 did not have an assessment or a physician order to self-administer her own medications. Administrative Nurse D stated her medication should not be left on her bedside table. The facility was unable to provide a policy related to resident self-medication administration. The facility failed to ensure safe and appropriate self-administration of medications for R22. This deficient practice had the risk of unnecessary medication side effects and self-administration errors for R22.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45668 The facility reported a census of 81 residents. The sample included 21 residents, with four reviewed for accommodation of needs. Based on interviews, observations, and record review, the facility failed to ensure Resident (R) 3 and R66 had the appropriate call light or other method to communicate their needs. This deficient practice placed the residents at risk for preventable accidents and injuries. Findings Included: - The Medical Diagnosis section within R3's Electronic Medical Records (EMR) included diagnoses of dysphagia (difficulty swallowing), muscle weakness, need for assistance with care, intellectual disabilities (a significantly below-average score on a test of mental ability or intelligence and limitations in the ability to function in areas of daily life), and obesity (severely overweight). R3's Quarterly Minimum Data Set (MDS) dated [DATE] noted a Brief Interview for Mental Status (BIMS) score of six indicating severe cognitive impairment. The MDS noted she used a wheelchair for mobility. The MDS noted she required partial to moderate assistance with bed mobility, transfers, dressing, bathing, personal hygiene, and toileting. The MDS noted she had upper extremity impairment to one side. R3's Functional Abilities Care Area Assessment (CAA) completed 01/11/24 indicated she was admitted to the facility with impaired speech. The CAA noted that screeching is the only sound she can make due to her intellectual disability. The CAA noted she required staff assistance with all activities of daily living (ADL). R3's Care Plan initiated on 09/04/18 noted she was admitted to the facility with severe cognitive loss, impaired speech, and poor memory. The plan noted staff were to ask her simple yes or no questions. The plan noted staff were to monitor her body language and facial expressions to further determine her needs. The plan noted staff were to ensure her call light remained within her reach when in her room. The plan noted she used a touchpad call light. The plan noted she was at risk for falls due to her impaired communication and cognition. On 03/10/25 at 07:10 AM, an inspection of R3's bed revealed her room had a push button call light in place. An inspection of the room revealed no soft-touch call light. On 03/12/25 at 07:20 AM, R3 rested in her bed. R3 had difficulty holding the small push-button call light when asked if she could operate it. On 03/12/25 at 12:16 PM, Certified Medication Aide (CMA) R stated the soft-touch call lights were meant for residents who could not hold or activate the push-button call lights. She stated that R3 should have a touch call light due to her difficulty holding the button. On 03/12/25 at 01:30 PM, Administrative Nurse D stated that R3's call light was just replaced with a touch light before the interview. She stated staff were expected to monitor the residents' care environments to ensure the correct care interventions and equipment were in place. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to provide a policy related to accommodation of needs or call lights as requested on 03/12/25. The facility failed to ensure R3 had the appropriate call light or other method to communicate their needs. This deficient practice placed the residents at risk for preventable accidents and injuries. 49634 - R66's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of major depressive disorder (major mood disorder that causes persistent feelings of sadness), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), hypertension (high blood pressure), dementia (a progressive mental disorder characterized by failing memory and confusion), muscle weakness, need for assistance with personal care, cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), hyperlipidemia (condition of elevated blood lipid levels), and dysphagia (swallowing difficulty). The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of five which indicated severely impaired cognition. The MDS documented R66 was independent with all activities of daily living (ADL) except bathing and required touching and cueing. The Admission MDS dated [DATE] documented a BIMS score of four which indicated severely impaired cognition. The MDS documented R66 was independent with eating and oral hygiene and needed partial to moderate assistance of staff from staff for bathing and upper and lower body dressing. The Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 08/19/24 documented R66 was admitted to the center post-hospital stay for therapy with diagnoses of hypertension and dementia. R66 was alert and orientated, able to voice her needs. Staff were to assist with toileting tasks as needed, R66 had occasional incontinence of the bladder. R66's Care Plan dated 08/27/24 documented staff would anticipate and meet R66's needs. R66's plan of care documented staff would ensure R66's call light was within her reach and encourage her to use the light for assistance, her plan of care documented R66 needed prompt responses to all requests for assistance, and staff would follow the facility's falls protocol. On 03/10/25 at 08:41 AM, R66 laid on her bed. R66's call light was wrapped with another call light. The call light dangled on the floor in the middle of R66's room. R66's call light was not in her reach. On 03/11/25 at 08:41 AM, R66 laid on her bed. R66's call light was wrapped with another call light. The call light dangled on the floor in the middle of R66's room. R66's call light was not in her reach. On 03/12/25 at 11:22 AM, Certified Medication Aide (CMA) R stated all residents should have access to their call light. She stated call lights should be within the resident's reach. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/12/25 at 12:41 PM, Licensed Nurse (LN) G stated it was all staff's responsibility to ensure residents have their call light within the resident's reach. On 03/12/25 at 01:30 PM, Administrative Nurse D stated the resident's call light was to be placed within the resident's reach. The facility failed to provide an accommodation of needs policy about call lights. The facility failed to ensure R66's call light was within her reach. This deficient practice left R66 vulnerable to unmet care needs due to the inability to call for staff assistance.

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634 The facility identified a census of 81 residents. The sample includes 21 residents, with five residents reviewed for resident funds. Based on observation, record review, and interviews, the facility failed to provide and or ensure resident funds accounts were accessible 24 hours a day seven days a week. This deficient practice placed residents at risk for decreased psychosocial well-being. Findings Included: - On [DATE] at 10:13 AM, Resident Council members Resident (R) 19, R53, and R65 reported the only way residents could access their money in their trust accounts was through Administrative Staff B. They reported that they were only aware that money withdrawals occurred Monday through Friday from 11:00 AM to 12:00 PM during the day. She stated we set a time because residents would be in my office all day long. On [DATE] at 11:431AM, Certified Medication Aide (CMA) R stated residents can get money on the weekends, she stated there was money in an envelope on the 300-hall cart. CMA R stated residents could ask for money on the weekends. On [DATE] at 12:17 PM, Licensed Nurse (LN) G stated residents could get money Monday through Friday. LN G stated residents could also get a small amount of money on the weekend from the nurse working hall 300. On [DATE] at 01:07 PM, Administrative Staff B stated the money was given out Monday-Friday from 11:, d+[DATE]:00 during the day. She stated there was a small amount of cash kept in the cart in the hall 300 residents had access to. She stated we set a time because residents would be in my office all day long. On [DATE] at 01:30 PM, Administrative Staff D reported the residents were informed on admission when they could get money. She stated residents were able to get cash Monday through Friday from 11:00 AM through 12:00 PM. Administrative D stated the money was kept in the business office, and residents' funds were distributed by the Activities Director. She stated residents could get cash on the weekends from the nurse working the 300 halls, cash was kept on her cart. The facility's Residents Trust policy documented the facility shall have standardized policies for the handling of resident trust accounts both active residents' funds and funds of deceased residents. Monitoring systems shall be in place to ensure funds were handled according to applicable state regulations. The facility would maintain at least $200.00 in petty cash, used specifically for withdrawals of cash for residents daily. All petty cash funds would be held on in cash in the facility Administrator's name and funds would be replenished upon recording residents spending into the resident trust system. The facility failed to ensure resident funds accounts were accessible 24 hours a day seven days a week. This deficient practice placed residents at risk for decreased psychosocial well.

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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 - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634 The facility identified a census of 81 residents. The sample included 21 residents, with one reviewed for abuse and/or neglect. Based on record review and interview, the facility failed to ensure Resident (R) 35 was free from abuse when R35's medication was misappropriated from the facility medication cart. This placed the residents at risk for both physical and psychosocial negative outcomes. Findings included: - R35's Electronic Medical Record (EMR) under the Diagnosis tab recorded diagnoses of hemiparesis/hemiplegia (weakness and paralysis on one side of the body) of the left nondominant side, Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), and dementia (a progressive mental disorder characterized by failing memory and confusion). The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of ten which indicated moderately impaired cognition. The MDS documented R35 received opioids (a class of controlled drugs used to treat pain) during the observation period. Review of R35's physician orders revealed R35 was receiving Oxycodone (pain medication) HCl Oral Tablet 5 MG (Oxycodone HCl) Give 1 tablet by mouth every 24 hours as needed for pain -Order start date 12/27/24 -discontinue (D/C) date 01/31/25. Review of the Complaint Investigation Witness Statement dated 01/28/25 documented when the Director of Clinical Operations arrived at the facility to help with locating the missing narcotic card, Administrative Nurse F looked in the count binder and confirmed the shift count sheet was present and complete. On 01/09/25 the receiving nurse of the narcotics did not log the medication into the narcotic inventory count. Review of the Complaint Concern log dated 01/28/25 documented when the Assistant Director of Nursing was notified of missing narcotics she immediately verified the medication book was on the medication cart, and the narcotic count sheet was present in the book. The ADON verified the current count was reconciled and correct. Review of the Custom Concern log dated 01/30/25 recorded an unknown resident was missing medication/ narcotics in a bubble pack and confirmed reimbursement of the cost of medication. Review of the Manual Check Request log documented a reimbursement for medication was given for missing medication for R35 in the amount of $13.43. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Investigation Template dated 01/30/25 documented a process was established where all controlled substances would be accounted for at each shift change to ensure accuracy and prevent discrepancies. Every controlled substance would be traced using Controlled Substances Count Sheets to ensure a detailed log was maintained. Any unused controlled substances would be disposed of following the Disposal of Controlled Substances guidelines. The facility would be doing regular audits of narcotic documentation three times per week for eight weeks to ensure compliance. Medication destruction audits would also take place monthly, in partnership with a pharmacy consultant. The facility was unable to determine an alleged perpetrator. The facility's process for controlled substance delivery and accountability had been modified to prevent future discrepancies. All nursing staff would undergo mandatory training on narcotic management and controlled substance accountability to ensure comprehensive understanding and adherence to new protocols. To maintain accountability an ensure the implemented interventions are effective, the results of ongoing audits would be shared at the monthly Quality Assurance and Performance Improvement (QAPI) meetings. All residents were evaluated to ensure proper pain management and to confirm no residents had missed any doses of prescribed medications. The police were called to ensure any potential criminal activity could be investigated. A review of staff training on 07/22/24 documented all staff were given Abuse and Neglect training. On 03/12/25 at 10:47 AM, Administrative Nurse D stated that Licensed Nurse (LN) G had received a controlled substance the previous day 01/09/25, and that LN G failed to sign the narcotic card into the narcotic count. Administrative nurse D stated the ADON was notified on 01/28/25. Administrative Nurse D stated the Administrator was notified immediately. Administrative Nurse D stated while investigating the missing bubble pack, other controlled cards were determined to be missing from the medication box to be destroyed. She stated the facility started training to ensure all cards were counted, and education on the medication destroy box. Administrative Nurse D stated the facility had not called the State because the facility did not feel there was abuse involved. She stated the facility figured out what happened to the medication but was unsure who the alleged perpetrator was. She stated the facility figured out the cards were taken. Administrative Nurse D stated she does not have documentation of ongoing audits, she walks by the carts and ensures the count was correct. She stated the facility reimbursed R35 for the medication, and he never missed a dose of pain medication. Administrative Nurse D stated the Abuse and Neglect training was started with all staff members. On 03/12/25 at 12:17 PM, Certified Medication Aide (CMA) R stated all narcotics were counted by the oncoming staff and outgoing staff on each shift. She stated she did not know what the process would be because she had never had anyone not count narcotics with her. On 03/12/25 at 12:41 PM, LN G stated it was the facility's policy to count narcotics with the oncoming and outgoing nurse each shift. She stated it was also the policy of the facility to document narcotic cards added to the narcotic count each shift. The facility's Abuse, Neglect and Exploitation dated 01/2019 documented the facility Administrator would oversee the implementation of corrective actions to protect all residents. The Administrator or designee would conduct an internal investigation against any violation/alleged violation of abuse, neglect, exploitation, injury of unknown source misappropriation of resident property, or involuntary seclusion and report the results of the investigation to the enforcement agency in accordance with state law including the state survey and certification agency within five working days of the incident or according to state law. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to ensure R35 was free from abuse when R35's medication was misappropriated from the facility medication cart. This placed the residents at risk for both physical and psychosocial negative outcomes.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634 The facility identified a census of 81 residents. The sample included 21 residents, with one reviewed for abuse and/or neglect. Based on record review and interview, the facility failed to submit a full investigation of a reportable occurrence for Resident (R) 35 to the appropriate state agency within twenty-four hours as required for misappropriation of R35's missing controlled substance. This placed the residents at risk for unidentified and ongoing abuse and /or neglect. Findings included: - R35's Electronic Medical Record (EMR) under the Diagnosis tab recorded diagnoses of hemiparesis/hemiplegia (weakness and paralysis on one side of the body) of the left nondominant side, Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), and dementia (a progressive mental disorder characterized by failing memory and confusion). The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of ten which indicated moderately impaired cognition. The MDS documented R35 received opioids (a class of controlled drugs used to treat pain) during the observation period. Review of R35's physician orders revealed R35 was receiving Oxycodone (pain medication) HCl Oral Tablet 5 MG (Oxycodone HCl) Give 1 tablet by mouth every 24 hours as needed for pain -Order start date 12/27/24 -discontinue (D/C) date 01/31/25. Review of the pharmacy delivery sheet documented 30 oxycodone tablets were delivered on 01/09/25. Review of the Complaint Investigation Witness Statement dated 01/28/25 documented when the Director of Clinical Operations arrived at the facility to help with locating the missing narcotic card, Administrative Nurse F looked in the count binder and confirmed the shift count sheet was present and completed. On 01/09/25 the receiving nurse of the narcotics did not log the medication into the narcotic inventory count. Review of the Complaint Concern log dated 01/28/25 documented when the Assistant Director of Nursing was notified of missing narcotics, she immediately verified the medication book was on the medication cart, and the narcotic count sheet was present in the book. The ADON verified the current count was reconciled and correct. Review of the Custom Concern log dated 01/30/25 recorded an unknown resident was missing medication/ narcotics in bubble packs and confirmed reimbursement of the cost of medication. Review of the Manual Check Request log documented a reimbursement for medication was given for missing medication for R35 in the amount of $13.43. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Investigation Template dated 01/30/25 documented a process was established where all controlled substances would be accounted for at each shift change to ensure accuracy and prevent discrepancies. Every controlled substance would be traced using Controlled Substances Count Sheets to ensure a detailed log was maintained. Any unused controlled substances would be disposed of following the Disposal of Controlled Substances guidelines. The facility would be doing regular audits of narcotic documentation three times per week for eight weeks to ensure compliance. Medication destruction audits would also take place monthly, in partnership with a pharmacy consultant. The facility was unable to determine an alleged perpetrator. The facility's process for controlled substance delivery and accountability has been modified to prevent future discrepancies. All nursing staff would undergo mandatory training on narcotic management and controlled substance accountability to ensure comprehensive understanding and adherence to new protocols. To maintain accountability and ensure the implemented interventions are effective, the results of ongoing audits would be shared at the monthly Quality Assurance and Performance Improvement (QAPI) meetings. All residents were evaluated to ensure proper pain management and to confirm no residents had missed any doses of prescribed medications. The police were called to ensure any potential criminal activity could be investigated. A review of staff training on 07/22/24 documented all staff were given Abuse and Neglect training. On 03/12/25 at 10:47 AM, Administrative Nurse D stated that Licensed Nurse (LN) G had received A controlled substance the previous day 01/09/25, the LN G failed to sign the narcotic card into the narcotic count. Administrative nurse D stated the ADON was notified on 01/28/25. Administrative Nurse D stated the Administrator was notified immediately. Administrative Nurse D stated while investigating the missing bubble pack, other controlled cards were determined to be missing from the medication box to be destroyed. She stated the facility started training to ensure all cards were counted, and education on the medication destroy box. Administrative Nurse D stated the facility had not called the State because the facility did not feel there was abuse involved. She stated the facility figured out what happened to the medication but was unsure who the alleged perpetrator was. She stated the facility figured out the cards were taken. Administrative Nurse Stated she does not have documentation of ongoing audits; she walks by the carts and ensures the count was correct. She stated the facility reimbursed R35 for the medication, and he never missed a dose of pain medication. Administrative Nurse D stated the Abuse and Neglect training was started with all staff members. On 03/12/25 at 12:17 PM, Certified Medication Aide (CMA) R stated all narcotics were counted by the oncoming staff and outgoing staff on each shift. She stated she did not know what the process would be because she had never had anyone not count narcotics with her. On 03/12/25 at 12:41 PM, LN G stated it was the facility's policy to count narcotics with the oncoming and outgoing nurse each shift. She stated it was also the policy of the facility to document narcotic cards added to the narcotic count each shift. The facility's Abuse, Neglect and Exploitation dated 01/2019 documented the facility Administrator would oversee the implementation of corrective actions to protect all residents. The Administrator or designee would conduct an internal investigation against any violation/alleged violation of abuse, neglect, exploitation, injury of unknown source misappropriation of resident property, or involuntary seclusion and report the results of the investigation to the enforcement agency in accordance with state law including the state survey and certification agency within five working days of the incident or according to state law. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to submit a full investigation of a reportable occurrence for R35 to the appropriate state agency within twenty-four hours as required, for misappropriation of R35's missing controlled substance. This placed the residents at risk for unidentified and ongoing abuse and /or neglect.

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. 49634 The facility identified a census of 81 residents. The sample included 21 residents. Based on observation, record review, and interviews, the facility failed to provide consistent weekend activities on Sundays to promote socialization. This deficient practice placed the affected residents at risk for decreased psychosocial well-being, boredom, and isolation. Findings included: - A review of the facility's Activity Calendar for January, February, and March 2025 was completed. The Activity Calendar for January 2025 recorded each Sunday listed church services at 02:00 PM. The Activity Calendar for February 2025 recorded each Sunday listed church services at 2:00 PM, Sunday 02/02/25 at 06:30 PM listed resident movie night, 02/09/25 at 06:30 PM listed game night, 02/16/25 at 06:30 listed resident chooses game night, and 02/23/25 at 06:30 listed resident movie night. The Activities Calendar for March 2025 recorded each Sunday listed church services at 02:00 PM, Sunday 03/02/25 at 06:30 PM listed residents choose a game to play, on 03/09/25 at 06:30 PM card games, on 03/16/25 at 0:6:30 PM board game, and on 03/23/25 listed movie time. On 03/11/25 at 10:00 AM, Resident Council members reported on Sundays, there were not many activities. The council reported they could go to church services. The Resident Council stated there were no consistent activities on Sundays, and residents stayed in their rooms and watched TV. The Resident Council stated the weekends get very long. The Resident council stated there are activities on the calendar for Sundays, these activities are supposed to be led by staff, they stated the staff are very busy and do not have time. On 03/12/25 at 01:05 PM, Activities Staff Z worked Monday through Friday, and the facility had church on Sundays, and either volunteers or staff-led activities on the weekends. On 03/12/25 at 12:17 PM, Certified Medication Aide (CMA) R, stated the resident could go to church on Sundays, and there were staff-led activities or volunteers on the weekends. On 03/12/25 at 01:20 PM, Administrative D stated the facility had volunteers on Sundays, and the nursing staff did Sunday activities in the evening. She stated the facility did one-to-one with residents who were unable to attend the Sunday activity. The facility's Activities policy dated 04/22 documented it was the policy of the center to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan, and preferences. Center-sponsored group, individual, and independent activities would be designed to meet the interest of each resident, as well as support their physical, mental, and psychosocial well-being. Activities would encourage both independence and interactions within the community. (continued on next page)

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to provide consistent weekend activities for the residents to promote socialization. This deficient practice placed the affected residents at risk for decreased psychosocial well-being, boredom, and isolation.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037 The facility identified a census of 81 residents. The sample included 21 residents with one resident reviewed for quality of care. Based on observation, record review, and interviews, the facility failed to follow a physician's order for daily weights to monitor for congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid) for Resident (R) 2. This deficient practice placed R2 at risk for delay in treatment related to fluid overload and untreated illness. Findings included: - R2's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), CHF, and edema (swelling resulting from an excessive accumulation of fluid in the body tissues). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 14 which indicated intact cognition. The MDS documented R2 was dependent on staff assistance with transfers. The MDS documented R2 had received diuretic medication (a medication to promote the formation and excretion of urine) during the observation period. The Quarterly MDS dated [DATE] documented a BIMS score of 12 which indicated moderately impaired cognition. The MDS documented that R2 was dependent on staff assistance with transfers. The MDS documented R2 had received diuretic medication during the observation period. R2's Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 10/16/24 documented he required assistance with activities of daily living. R2's Care Plan dated 01/24/25 documented nursing staff would monitor his weight as ordered. R2's EMR under the Orders tab revealed the following physician orders: Daily weights using the same modality each time (Hoyer lift- total body mechanical lift) one time a day for CHF dated 09/02/24. Bumex (diuretic) oral tablet give two milligrams (mg) by mouth two times a day for CHF dated 09/09/24. Review of R2's Medication Administration Record (MAR) from 02/01/25 to 03/10/25 (37 days) lacked evidence staff measured and recorded R2's weight) on following three dates 02/20/25, 02/28/25, and 03/02/25. The MAR documented R2 had refused on the following two dates 02/10/25 and 02/14/25. The MAR documented R2 was asleep on 02/13/25. The MAR documented R2's weight was on hold the five dates 02/03/25, 02/04/25, 02/05/25, 02/08/25, and 02/11/25. The MAR documented other/see progress notes on the following two dates 02/02/25 and 02/09/25. The clinical record lacked documentation of physician notification of daily weight was not obtained. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/11/25 at 09:51 AM, R2 was asleep on his back on the bed. R2's side rails were up and locked on both sides of the bed. R2's pressure relieving devices were in place on his lower extremities. On 03/12/25 at 12:17 PM, Certified Medication Aide (CMA) R stated everyone would assist in obtaining the daily weights. CMA R stated the charge nurse would enter the weights into the resident's EMR. On 03/12/25 at 12:42 PM, Licensed Nurse (LN) G stated everyone was responsible for obtaining the daily weights. LN G stated the nurse would enter the daily weights in the resident's MAR. LN G stated the physician should be notified of any daily weights that were not obtained and the notifications would be documented in the resident's progress notes. On 03/12/25 at 01:29 PM, Administrative Nurse D stated she expected the charge nurse to ensure the daily weights were obtained and recorded. Administrative Nurse D stated the physician should be notified of any daily weights not obtained and a progress note written with the physician's response. The facility failed to provide a policy related to quality of care. The facility failed to follow a physician's order for daily weights related to R2's CHF. This deficient practice placed R2 at risk of adverse side effects from unnecessary medication or complications related to fluid overload.

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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 - Some	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** 45668 The facility had a census of 81 residents. The sample included 21 residents, with two reviewed for accidents. Based on observation, record review, and interview, the facility failed to ensure the safe storage of medications, pressurized oxygen cylinders, and chemical agents from eleven cognitively impaired independently mobile residents. The facility additionally failed to ensure Resident (R) 130's bed remained at a safe height per her care-planned interventions. This deficient practice placed the affected residents at risk for preventable accidents and injuries. Findings Included: - On 03/10/25 at 07:04 AM, an initial walkthrough of the facility was completed: An inspection of the supplemental oxygen storage closet revealed that the entry door was unlocked. The closet contained 79 fully compressed oxygen cylinder tanks stored in floor racks. At 07:10 AM, Licensed Nurse (LN) H inspected the door and found it was unlocked because the manual latch was not turned on the handle. LN H stated that the closet and oxygen rooms should remain locked. An inspection of the 100-Hall revealed the shower room was propped open. An inspection of the shower room revealed an unsecured bottle of multi-surface disinfectant. The bottle contained the warning, Keep out of reach from children. An inspection of the treatment cart positioned at the entrance of the 300 Hall revealed the cart was left unlocked and unattended. The cart revealed unsecured medication and prescription ointments. (Refer to F761) On 03/10/25 at 07:59 AM, an inspection of the 300 Hall revealed an unlocked medication cart with the keys in the lock left unattended outside by R9's room. The cart contained medications and prescribed ointments. (Refer to F761) On 03/10/25 at 08:49 AM, an inspection of R22's room revealed her morning medications were left unattended on her bedside table as R22 slept in her bed. (Refer to F554) On 03/10/25 at 09:20 AM, an inspection of the 300 Hall's Quiet Room revealed an unlocked medication cart. The cart contained medicated creams and ointments. (Refer to F761) On 03/11/25 at 09:48 AM R22's medications were again left on her bedside table unattended as she slept in her bed. (Refer to F554) On 03/12/25 at 12:16 AM, Certified Medication Aide (CMA) stated the oxygen storage rooms and medication carts were to be locked when not in use or unsupervised. She stated nurses and medication aides have been educated not to leave the carts unlocked. On 03/12/25 at 01:24 PM, Administrative Nurse D stated staff were expected to check the oxygen rooms and medication cart to ensure they were secured before leaving them. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Medication Storage policy dated 04/2020 indicated the facility will ensure the safe storage of medications and biologicals in a secure area per the manufacturer's recommendation. The facility failed to ensure the safe storage of medications, pressurized oxygen cylinders, and chemical agents from eleven cognitively impaired independently mobile residents. This deficient practice placed the affected residents at risk for preventable accidents and injuries. 41037 - R130's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of hemiparesis (muscular weakness of one half of the body), hemiplegia (paralysis of one side of the body), 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) affecting her dominant right side. The Significant Change Minimum Data Set (MDS) dated [DATE] documented she had severely impaired cognition. The MDS documented R130 had an impaired range of motion (ROM - the full movement potential of a joint, usually its range of flexion and extension) on one side of her upper and lower extremities. The MDS documented R130 was dependent on staff assistance for all activities of daily living (ADL). R130's Falls Care Area Assessment (CAA) dated 02/14/25 documented she required total assistance with transfers and mobility. R130's Care Plan last revised on 03/10/25 directed the staff to keep her bed in a low position while she was in bed for safety. On 03/10/25 at 07:40 AM, R130 laid on her back in the bed. R130's bed was elevated four feet off the floor. On 03/11/25 at 08:20 AM, R130 laid on the left side of the bed facing the open door. R130's bed was elevated three feet off the floor and her right shoulder was exposed to the hallway. On 03/12/25 at 12:17 PM, Certified Medication Aide (CMA) R stated fall interventions could be found on the Kardex (nursing tool that gives a brief overview of the care needs of each resident). CMA R stated if a bed was to be in the low position that information would be included on the Kardex. On 03/12/25 at 12:42 PM, Licensed Nurse (LN) G stated the interventions for falls were listed on the care plan and Kardex. LN G stated R130's bed should be in the lowest position. LN G stated it was the charge nurse's responsibility to ensure fall interventions were in place. On 03/12/25 at 01:29 PM, Administrative Nurse D stated the fall interventions could be found on the resident's care plan or the Kardex. Administrative Nurse D stated she would expect everyone to ensure a resident's fall interventions were in place at all times. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Fall Prevention policy documented the facility was to identify risks and establish interventions to mitigate the occurrence of falls. The facility would provide a comprehensive care plan to include the preventative interventions that would be initiated and placed on the Kardex (a nursing tool that gives a brief overview of the care needs of each resident) for all team members to review. The identified interventions would be communicated to all team members by the fall prevention team. The facility failed to ensure R130's bed was kept in the lowest position when she was in the bed for safety. This deficient practice placed R130 at further risk for injuries related to falls.

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 45668 The facility identified a census of 81 residents. The sample included 21 residents. Based on observations, interviews, and record reviews, the facility failed to ensure staff possessed the appropriate skills and knowledge to safely handle, store, and administer resident medications. This deficient practice placed the residents at risk for potential medication errors and side effects. Findings included: - A Complaint Investigation Witness Statement completed 01/28/25 revealed the facility was unable to locate Resident (R) 35's prescribed five-milligram oxycodone (controlled substance pain medication with a high potential for abuse and dependency) pill card. The report indicated the pill card contained 30 individually packed and numbered for use. The report indicated the facility received the medication pill card on 01/09/25 and was placed in the narcotic lock box. The report indicated the narcotic count was updated to include the new card. The report indicated the missing count sheet and pill card were identified as missing on 01/28/25. The report indicated the facility was unable to identify when the card was last verified or seen by staff since being placed in the narcotic lock box. The report indicated that 11 other medication cards went missing from the designated medication destruction/disposal box. The report's Root-Cause Analysis indicated the facility would start a process for each controlled substance to be accounted for each shift change, use controlled substances tracking sheets, and follow the controlled substances per the disposal guidelines. On 03/10/25 at 07:04 AM, an initial walkthrough of the facility revealed a treatment cart in the 300 Hall was left unlocked and unattended by nursing staff. The cart contained prescription medications and ointments. (Refer to F761) On 03/10/25 at 07:59 AM, an inspection of the 300 Hall revealed an unlocked medication cart with the keys in the lock left unattended outside by R9's room. The cart contained medications and prescribed ointments. (Refer to F761) On 03/10/25 at 08:49 AM, an inspection of R22's room revealed her morning medications were left unattended on her bedside table as R22 slept in her bed. (Refer to F554) On 03/10/25 at 09:20 AM, an inspection of the 300 Hall's Quiet Room revealed an unlocked medication cart. The cart contained medicated creams and ointments. (Refer to F761) On 03/11/25 at 09:48 AM, R22's medications were again left on her bedside table unattended as she slept in her bed. (Refer to F554) (continued on next page)

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 03/12/25 at 12:16 AM, Certified Medication Aide (CMA) R stated the medication carts were to be locked when not in use or unsupervised. She stated nurses and medication aides have been educated not to leave the carts unlocked. She stated medication should never be left unsupervised in the resident's rooms. She stated staff should complete narcotics counts at each shift change to verify all medications were present. On 03/12/25 at 12:35 PM, Licensed Nurse (LN) G stated staff were expected to lock the med carts when they walked away from them. She stated nursing staff were expected to complete and sign off on narcotic medications at the beginning of each shift with two nurses signing. She stated staff should never leave medications in the resident's rooms unsupervised. On 03/12/25 at 01:24 PM, Administrative Nurse D stated staff were expected to check the medication carts to ensure they were secured before leaving them. She stated the nurses were expected to count and verify narcotic cards each shift as a correction plan for the loss of medications. She stated medications were expected to be destroyed with two nurses witnessing and signing off. The facility was unable to provide a policy related to competent staffing as requested on 03/13/25. The facility failed to ensure staff possessed the appropriate skills and knowledge to safely handle, store, and administer resident medications. This deficient practice placed the residents at risk for potential medication errors and side effects.

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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** 45668 The facility identified a census of 81 residents. The sample included 21 residents, with one reviewed for dementia (a progressive mental disorder characterized by failing memory, and confusion) care. Based on interviews, record reviews, and observations, the facility failed to provide dementia-related care services for Resident (R) 12 to promote the resident's highest practicable level of well-being. This deficient practice placed R12 at risk for decreased quality of life, isolation, and impaired dignity. Findings Included: - The Medical Diagnosis section within R12's Electronic Medical Records (EMR) included diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), dysphagia (difficulty swallowing), cognitive-communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), insomnia (difficulty sleeping), and need for assistance with personal cares. R12's Annual Minimum Data Set (MDS) dated [DATE] noted a Brief Interview for Mental Status (BIMS) score of six indicating severe cognitive impairment. The MDS noted she used a wheelchair for mobility. The MDS noted she required partial to moderate assistance with bed mobility, transfers, dressing, bathing, personal hygiene, and toileting. The MDS noted no recent falls. R12's Functional Abilities Care Area Assessment (CAA) completed 02/16/25 indicated she was alert with some confusion. The CAA noted she may or may not voice her needs for assistance and had poor safety awareness. The CAA instructed staff to assist her with her daily care. R12's Care Plan initiated 06/03/24 indicated she had a self-care deficit related to her impaired cognition and dementia. The plan noted she required the assistance of one staff for transfers, dressing, bathing, bed mobility, grooming, and toileting. The plan instructed staff to provide hair, nail, and oral care daily and as needed. The plan lacked indication or interventions related to her dementia-related behaviors or refusal of care. R12's EMR under Progress Notes completed on 03/10/25 documented R12 transferred herself from her wheelchair to the nurse's station chair and began grabbing items off the nurse's desk. The note revealed staff were unable to redirect her and she remained at the station for four to five hours. The note indicated she eventually agreed to go to bed. R12's EMR under Progress Notes completed on 11/20/24 documented R12 was confused and asked to call a cab to go home. The note reported that R12 informed staff she had no money and didn't want to stay. The note indicated staff offered pudding but R12 refused to eat it. R12's EMR under Progress Notes completed on 09/29/24 documented R12 was educated not to eat roommates' food or drinks. The note indicated she was educated to keep her hands to herself. (continued on next page)

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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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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R12's EMR under Progress Notes revealed a note completed on 09/20/24 documented indicated R12 became agitated at staff and threw a water pitcher while staff attempted a check and change. The note indicated she then threw feces at staff. The note indicated staff were unable to redirect R12. No other interventions were noted. R12's EMR under Documentation Survey Report from 01/01/2025 to 03/12/25 (70 days reviewed) revealed she received bathing on 10 occasions: 01/02/25, 01/06/25, 01/20/25, 01/23/25, 01/30/25, 02/03/25, 02/17/25, 03/03/25, 03/06/25, and 03/10/25. The report noted she refused on nine occasions in the reviewed period. R12's EMR revealed no rationale or interventions offered for the refused bathing occurrences. On 03/10/25 at 07:40 AM, R12 sat in the dining area. R12's hair was greasy and uncombed. She reported she was not sure when her last bathing occurrence was and if staff offered to comb her hair. On 03/11/25 at 12:30 PM, R12 sat in her wheelchair in the dining room. Her hair was uncombed. On 03/12/25 at 11:30 AM, Certified Medication Aide (CNA) R stated that R12 had a history of refusing care and bathing. She stated staff would often ask to provide bathing assistance and report to the nurse if she refused. She stated that R12 would also refuse to allow staff to assist with grooming and activities. She stated staff would allow time for R12 to calm down and reoffer the care. On 03/12/25 at 11:45 AM, Licensed Nurse (LN) G stated that R12 refused bathing and care frequently. She stated staff should offer alternative care if she did not want bathing or showers. She stated R12 sometimes had confusion but rarely was aggressive or not redirectable. She stated offering R12 a snack was often effective. She stated the care plan should identify her behaviors and provide interventions to help staff understand how to calm her down. On 03/12/25 at 01:30 PM, Administrative Nurse D stated that R12 was often redirectable and loved sugary snacks. She stated staff were expected to be patient and allow her time to process what was asked. She stated staff were expected to provide options and alternatives to R14 if she refused her daily care. She stated staff were expected to chart refusals and note what interventions were attempted. The facility's Dementia Care revised 01/2016 noted the facility was to ensure care was provided in a consistent and dignified manner. The policy noted staff were to re-approach residents after refusals and respond to any behaviors of distress to ensure all unmet needs were addressed. The facility failed to provide dementia-related care services for R12 to promote the resident's highest practicable level of well-being. This deficient practice placed R12 at risk for decreased quality of life, isolation, and impaired dignity.

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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** 41037 The facility identified a census of 81 residents. The sample included 21 residents, with six residents reviewed for unnecessary medications. Based on observation, record review, and interviews, the facility failed to ensure the physician reviewed and addressed the Consultant Pharmacist (CP) recommendations for Resident (R) 61's as needed psychotropic medication (alters mood or thought). The facility also failed to ensure the CP identified and reported irregularities regarding lack of dosing instructions for Voltaren (topical pain reliever medication) gel and the lack of monitoring antihypertensive (a class of medication used to treat high blood pressure) medications for R54. The facility also failed to ensure the CP identified and reported irregularities regarding lack of documentation of R14's oxygen saturation monitoring. These deficient practices placed these residents at risk for adverse medication effects and unnecessary medications. Findings included: - R61's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 13 which indicated intact cognition. The MDS documented R61 had received insulin (medication to regulate blood sugar), antidepressant (a class of medications used to treat mood disorders), diuretic (a medication to promote the formation and excretion of urine) medication, and opioid (a class of controlled drugs used to treat pain) medication during the observation period. The MDS lacked documentation a gradual dose reduction (GDR) was attempted. The MDS also lacked documentation there was physician documentation a GDR was contraindicated. The MDS lacked documentation a drug regimen review was completed during the observation period. The Quarterly MDS dated [DATE] documented a BIMS score of 13 which indicated intact cognition. The MDS documented that R61 had received insulin, antidepressant medication, diuretic medication, and opioid medication during the observation period. The MDS lacked documentation a GDR was attempted. The MDS also lacked documentation there was physician documentation a GDR was contraindicated. The MDS lacked documentation a drug regimen review was completed during the observation period. R61's Psychotropic Drug Use Care Area Assessment (CAA) dated 06/19/24 documented the physician, pharmacist, and nursing staff would monitor her for adverse side effects of her psychotropic medications. R61's Care Plan dated 05/08/24 documented the nursing staff would administer her medication as ordered. The plan of care documented the nursing staff would monitor for side effects and effectiveness. R61's EMR under the Orders tab revealed the following physician orders: (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Trazodone (antidepressant) hcl oral tablet 50 milligrams (mg) give half tablet (25mg) by mouth as needed for behaviors; anxiety doctor does not care how close two doses are as long as only two doses a day dated 03/07/25. Review of R61's Monthly Medication Review (MMR) from February 2024 through February 2025 provided by the facility, lacked evidence the attending physician had reviewed or addressed the CP's recommendation from 10/17/24. The facility was unable to provide evidence the physician reviewed the recommendations made on 10/17/24 upon request. Review of R61's EMR under the Progress Notes tab a Pharmacy Review note dated 10/17/24 at 05:11 PM documented recommendations were made, review of the Clinical Pharmacy Report Review R61's EMR under the Documents tab revealed an unaddressed and unsigned Monthly Medication Review (MMR) dated 10/17/24. On 03/11/25 at 07:20 AM, R61 propelled herself in the wheelchair to the dining room. On 03/12/25 at 12:42 PM, Licensed Nurse (LN) G stated she would review the MMRs at times after the physician had reviewed and signed the recommendations. LN G stated she made any changes in the resident's EMR. On 03/12/25 at 01:29 PM, Administrative Nurse D stated she would expect the as-needed psychotropic medications to have a 14-day stop date or duration for the administration ordered. Administrative Nurse D stated that R61's attending physician was notified of the CP's irregularities and failed to respond or address the recommendations. The facility's Medication Regimen Review (MRR) policy dated 11/28/16 documented the center would meet MRR requirements including the timely notification of consultant pharmacist identified irregularities that require urgent action to protect patients/residents. The center would encourage the Physician/Prescriber or other Responsible Parties receiving the MRR to act upon the recommendations contained in the MRR. The attending physician would document the identified irregularity has been reviewed and what, if any, action has been taken to address the recommendations. If the attending physician has decided to make no change in the medication, the attending physician should document the rationale in the residents' health records. The center would alert the Medical Director when MRRs are not addressed by the attending physician/prescriber in a timely manner. The facility failed to ensure the physician reviewed and addressed the CP recommendations for R61. This deficient practice placed R61 at risk for unnecessary medication use, side effects, and physical complications. 41713 (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- R14's Electronic Medical Record (EMR) documented diagnoses of hypertension (HTN - elevated blood pressure), chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), heart failure (a condition where the heart is unable to pump enough blood to meet the body's needs), diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods), schizoaffective disorder (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), and fracture of left tibia (broken bone of the lower leg). R14's Significant Change Minimum Data Set (MDS) dated [DATE], documented he had a Brief Interview for Mental Status (BIMS) score of 10, which indicated moderately impaired cognition. R14 required substantial assistance to dependent on staff for functional abilities and activities of daily living (ADL). R14 required the use of a wheelchair for mobility. R14 took an anticoagulant (a class of medications used to prevent the blood from clotting), an antidepressant (a class of medications used to treat mood disorders), an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), and insulin (a hormone that lowers the level of glucose in the blood) regularly. R14 required oxygen therapy. R14's Functional Abilities Care Area Assessment (CAA) dated 11/04/24, documented that he was alert, had some confusion and was able to voice his needs for assistance. R14 needed assistance for ADLs, and could be self-limiting, and may refuse care. R14 was participating in therapy but had a history of refusing. R14 will remain at the long-term care center. R14's Care Plan, revised on 02/12/25, directed staff to monitor him for acute signs and symptoms of respiratory insufficiency and to notify the physician. R14's care plan lacked staff direction about maintaining his O2 saturation levels above 90%. R14's Orders tab of the EMR documented a physician's order dated 10/23/24 to maintain O2 saturation (percentage of oxygen in the blood) above 90 percent (%) every shift for COPD respiratory failure. This order was discontinued on 02/21/25. R14's Orders tab of the EMR documented a physician's order dated 02/22/25 to maintain O2 saturation (percentage of oxygen in the blood) above 90 percent (%), R14 was currently on room air. A review of R14's Orders tab of the EMR lacked any order to administer supplemental O2 if his O2 saturation was below 90%. A review of the CP's Note to Attending Physician/Prescriber recommendations from October 2024 to February 2025 revealed no recommendation to monitor and document his O2 saturation. A review of R14's Medication Administration Record (MAR) and Treatment Order Record (TAR) from October 2024 to 02/21/25 revealed the O2 saturation had been obtained and documented three times daily as ordered. A review of R14's MAR and TAR from 02/22/25 to the present revealed that staff had signed off on the order to maintain O2 saturation above 90%, but the TAR lacked monitoring and documenting of the O2 saturation reading on 14 of 14 opportunities. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R14's MAR and TAR for March 2025 revealed that staff had not obtained and documented R14's O2 saturation on 20 of 20 opportunities. On 03/11/25 at 09:18 AM, R14 laid on his back on his bed. R14's head of the bed was elevated, and the call light was within reach. On 03/12/25 at 01:30 PM, Administrative Nurse D stated she would expect the CP to identify and report if R14's O2 saturation level was not being monitored and documented on the TAR. Administrative Nurse D stated that R14's order had been changed recently to be done only twice daily. Administrative Nurse D stated the order had not been input correctly to include documenting the O2 reading. The CP could not be reached for an interview. The facility's Medication Regimen Review (MRR) policy dated 11/28/16 documented the center would meet MRR requirements including the timely notification of consultant pharmacist identified irregularities that require urgent action to protect patients/residents. The center would encourage the Physician/Prescriber or other Responsible Parties receiving the MRR to act upon the recommendations contained in the MRR. The attending physician would document that the identified irregularities were reviewed and what, if any, action has been taken to address the recommendations. If the attending physician has decided to make no change in the medication, the attending physician should document the rationale in the residents' health records. The center would alert the Medical Director when MRRs are not addressed by the attending physician/prescriber in a timely manner. The facility failed to ensure the CP identified and reported R14's O2 not being monitored and documented as the physician ordered. This placed R14 at risk for unnecessary medication administration and related complications. - R54's Electronic Medical Record (EMR) documented diagnoses of Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid), dementia (a progressive mental disorder characterized by failing memory and confusion), and osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk). R54's Admission Minimum Data Set (MDS) dated [DATE], documented she had a Brief Interview for Mental Status (BIMS) score of 10 which indicated moderately impaired cognition. R54 required moderate assistance from staff for oral hygiene, upper body dressing, and personal hygiene. R54 was dependent on staff assistance with all other functional abilities and activities of daily living (ADL). R54 used a wheelchair to assist with mobility. R54 received an anticoagulant (a class of medications used to prevent the blood from clotting), a diuretic (a medication to promote the formation and excretion of urine), and other medications regularly. R54's Functional Abilities Care Area Assessment (CAA) dated 10/08/24, documented she was alert, orientated, and able to voice her needs. R54 required assistance from staff for all daily care. R54 minimally participated in therapy. R54's Care Plan revised on 03/10/25, directed staff to administer medications as ordered. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R54's Orders Tab of the EMR documented a physician's order dated 10/03/24 for digoxin (a medication used to treat heart rhythm disorders) 125 milligrams (mg) to give one tablet by mouth one time a day for atrial fibrillation (A-Fib - a rapid, irregular heartbeat). This order was discontinued on 02/12/25. This order lacked a parameter for the pulse. R54's Orders Tab of the EMR documented a physician's order dated 02/25/25 for metoprolol succinate (a beta blocker medication) 100 mg by mouth daily for HTN. The order lacked a parameter for the blood pressure and pulse. R54's Orders tab of the EMR documented a physician's order dated 02/25/25 for digoxin 125 mg by mouth daily for A-Fib. This order lacked a parameter for the pulse prior to administration. R54's Orders tab of the EMR documented a physician's order for diclofenac (a topical medication used to treat mild to moderate pain and arthritis) one percent (1%) gel to be applied to the knees and shoulders topically three times daily. This order lacked a dosage amount to be applied to the affected areas. A review of R54's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for October 2024 to March 2025 revealed that a pulse reading was not obtained and documented before the administration of her physician-ordered digoxin. R54's blood pressure and pulse were not monitored and documented prior to the administration of her physician-ordered metoprolol. A review of the CP's Note to Attending Physician/Prescriber recommendations from October 2024 to February 2025 revealed the CP failed to identify and recommend monitoring and documenting R54's pulse before the administration of digoxin, the blood pressure, and pulse before the administration of metoprolol, and failed to identify R54's diclofenac lacked a dosage amount. On 03/11/25 at 12:05 PM, R54 was propelled by staff from her room to the dining room for lunch. On 03/12/25 at 12:16 PM, Certified Medication Aide (CMA) R stated a pulse should be obtained and documented before digoxin was given to make sure the pulse was not too low. CMA R stated she thought that blood pressure and pulse should be taken before giving a beta blocker like metoprolol. On 03/12/25 at 12:41 PM, Licensed Nurse (LN) G stated that when a medication was entered into the EMR it should ask the person entering the order if it was a blood pressure medication there should be a pulse and or a blood pressure reading obtained before administration. LN G stated any order should indicate a dosage amount to give or apply. On 03/12/25 at 01:30 PM, Administrative Nurse D stated all medications should have a dosage amount. Administrative Nurse D stated the physician or the nurse practitioner input their own orders into the EMR, but the nurses would enter orders if a phone order was received when a resident returned from an appointment, or from the hospital. Administrative Nurse D expected staff to ensure that a pulse was obtained prior to administration of digoxin as well as a blood pressure for metoprolol. The CP could not be reached for an interview. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Medication Regimen Review (MRR) policy dated 11/28/16 documented the center would meet MRR requirements including the timely notification of consultant pharmacist identified irregularities that require urgent action to protect patients/residents. The center would encourage the Physician/Prescriber or other Responsible Parties receiving the MRR to act upon the recommendations contained in the MRR. The attending physician would document that the identified irregularity has been reviewed and what if any, action has been taken to address the recommendations. If the attending physician has decided to make no change in the medication, the attending physician should document the rationale in the residents' health records. The center would alert the Medical Director when MRRs are not addressed by the attending physician/prescriber in a timely manner. The facility failed to ensure that the CP identified and reported when R54's physician-ordered diclofenac gel lacked a dosage amount. The facility further failed to ensure the CP identified and reported that R54's pulse had not been obtained prior to the administration of digoxin and failed to ensure R54's blood pressure had been obtained prior to the administration of metoprolol. These deficient practices placed R54 at risk of unnecessary medication administration and related complications.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41713 The facility identified a census of 81 residents. The sample included 21 residents, with five sampled residents reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to ensure that Resident (R) 14's oxygen (O2) saturation was monitored and documented as physician ordered. The facility failed to ensure staff monitored and documented R54's pulse for her antiarrhythmic (medications used to treat abnormal heart rhythms) and R54's blood pressure for her beta blocker (a medication used to treat high blood pressure and other cardiac conditions). This deficient practice placed these residents at risk for unnecessary medication administration and related complications. Findings included: - R14's Electronic Medical Record (EMR) documented diagnoses of hypertension (HTN - elevated blood pressure), chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), heart failure (a condition where the heart is unable to pump enough blood to meet the body's needs), diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods), schizoaffective disorder (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), and fracture of left tibia (broken bone of the lower leg). R14's Significant Change Minimum Data Set (MDS) dated [DATE], documented he had a Brief Interview for Mental Status (BIMS) score of 10, which indicated moderately impaired cognition. R14 required substantial assistance to dependent on staff for functional abilities and activities of daily living (ADL). R14 required the use of a wheelchair for mobility. R14 took an anticoagulant (a class of medications sued to prevent the blood from clotting), an antidepressant (a class of medications used to treat mood disorders), an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), and insulin (a hormone that lowers the level of glucose in the blood) regularly. R14 required oxygen therapy. R14's Functional Abilities Care Area Assessment (CAA) dated 11/04/24, documented that he was alert, had some confusion, and was able to voice his needs for assistance. R14 needed assistance for ADLs, and can be self-limiting, and may refuse cares. R14 was participating in therapy but had a history of refusing. R14 will remain at the long-term care center. R14's Care Plan, revised on 02/12/25, directed staff to monitor him for acute signs and symptoms of respiratory insufficiency, and to notify the physician. R14's care plan lacked staff direction about maintaining his O2 saturation levels above 90%. R14's Orders tab of the EMR documented a physician's order dated 02/21/25 for O2 to maintain O2 saturation (percentage of oxygen in the blood) above 90 percent (%). (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R14's Medication Administration Record (MAR) and Treatment Order Record (TAR) for February 2025 revealed that staff had signed off on the order to maintain O2 saturation above 90%. The TAR lacked monitoring and documenting of the O2 saturation reading on 14 of 14 opportunities. A review of R14's MAR and TAR for March 2025 revealed that staff had not obtained and documented R14's O2 saturation on 20 of 20 opportunities. On 03/11/25 at 09:18 AM, R14 laid on his back on his bed. R14's head of the bed was elevated, and the call light was withing reach. On 03/12/25 at 12:16 PM, Certified Medication Aide (CMA) R, stated that if a resident had an order for O2 saturation, the MAR or TAR should have a place where the O2 reading can be documented. On 03/12/25 at 12:41 PM, Licensed Nurse (LN) G stated R14's MAR or TAR should have a slot on the O2 order where the O2 saturation reading could be documented. LN G stated when the order was input into the EMR it must not been marked to include the slot to enter the O2 saturation reading. LN G stated R14's O2 saturation should be monitored and documented. On 03/12/25 at 01:30 PM, Administrative Nurse D stated if a resident was receiving O2 the saturation level should be monitored and documented on the TAR. Administrative Nurse D stated when the order was input into the EMR the staff member did not mark the area for the reading. Administrative Nurse D stated that R14's MAR/TAR would be updated to ensure the O2 reading was obtained. The Verbal Orders policy dated February 2025 documented physician orders may be received by telephone, by a licensed nurse or other licensed or registered health care specialist who was legally authorized to do so. Enter the order into the medical record electronically as per the software system guidelines. The facility failed to ensure the nursing staff monitored and documented R14's O2 saturation as physician ordered. This placed R14 at risk for unnecessary medication administration and related complications. - R54's Electronic Medical Record (EMR) documented diagnoses of Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid), dementia (a progressive mental disorder characterized by failing memory and confusion), and osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk. R54's Admission Minimum Data Set (MDS) dated [DATE], documented she had a Brief Interview for Mental Status (BIMS) score of 10 which indicated moderately impaired cognition. R54 required moderate assistance from staff for oral hygiene, upper body dressing, and personal hygiene. R54 was dependent on staff assistance with all other functional abilities and activities of daily living (ADL). R54 used a wheelchair to assist with mobility. R54 received an anticoagulant (a class of medications sued to prevent the blood from clotting), a diuretic (a medication to promote the formation and excretion of urine), and other medications regularly. (continued on next page)

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	175133	A. Building B. Wing	03/12/2025

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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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R54's Functional Abilities Care Area Assessment (CAA) dated 10/08/24, documented she was alert, and orientated, and able to voice her needs. R54 required assistance from staff for all daily cares. R54 minimally participated in therapy. R54's Care Plan revised on 03/10/25, directed staff to administer medications as ordered. R54' Orders Tab of the EMR documented a physician's order dated 10/03/24 for digoxin (a medication used to treat heart rhythm disorders) 125 milligrams (mg) to give one tablet by mouth one time a day for atrial fibrillation (A-Fib - a rapid, irregular heartbeat). This order was discontinued on 02/12/25. This order lacked a parameter for the pulse. R54' Orders Tab of the EMR documented a physician's order dated 02/25/25 for metoprolol succinate (a beta blocker medication) 100 mg by mouth daily for HTN. The order lacked a parameter for the blood pressure and pulse. R54's Orders tab of the EMR documented a physician's order dated 02/25/25 for digoxin 125 mg by mouth daily for A-Fib. This order lacked a parameter for the pulse prior to administration. R54's Orders tab of the EMR documented a physician's order for diclofenac (a topical medication used to treat mild to moderate pain and arthritis) one percent (1%) gel to be applied to the knees and shoulders topically three times daily. This order lacked a dosage amount to be applied to the affected areas. A review of R54's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for October 2024 to March 2025 revealed that a pulse reading was not obtained and documented before the administration of her physician-ordered digoxin. R54's blood pressure and pulse was not monitored and documented prior to administration of her physician-ordered metoprolol. On 03/11/25 at 12:05 PM, R54 was propelled by staff from her room to the dining room for lunch. On 03/12/25 at 12:16 PM, Certified Medication Aide (CMA) R stated a pulse should be obtained and documented before digoxin was given to make sure the pulse was not too low. CMA R stated she thought that a blood pressure and pulse should be taken before given a beta blocker like metoprolol. On 03/12/25 at 12:41 PM, Licensed Nurse (LN) G stated that when a medication was entered into the EMR it should ask the person entering the order if it was a blood pressure medication there should be a pulse and or a blood pressure reading obtained before administration. LN G stated any order should indicate a dosage amount to give or apply. On 03/12/25 at 01:30 PM, Administrative Nurse D stated all medications should have a dosage amount. Administrative Nurse D stated the physician, or the nurse practitioner input their own orders into the EMR, but the nurses would enter orders if a phone order was received, when a resident returned from an appointment, or from the hospital. Administrative Nurse D expected staff to ensure that a pulse was obtained prior to administration of digoxin as well as a blood pressure for metoprolol. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Verbal Orders policy dated February 2025 documented physician orders may be received by telephone, by a licensed nurse or other licensed or registered health care specialist who was legally authorized to do so. Enter the order into the medical record electronically as per the software system guidelines. The facility did not provide a policy regarding unnecessary medications as requested. The facility failed to ensure that R54's physician-ordered diclofenac gel had a dosage amount. The facility further failed to ensure that R54's pulse was obtained prior to administration of digoxin and failed to ensure R54's blood pressure was obtained prior to administration of metoprolol. These deficient practices placed R54 at risk of unnecessary medication administration and related complications.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 41037 The facility identified a census of 81 residents. The sample included 21 residents, five medication carts and three medication rooms. Based on observation, record review, and interviews, the facility failed to properly store medications in three of the five medication carts. The facility also failed to label medication in one of the five medication carts. This placed the residents at risk for adverse outcomes or ineffective medication regimens. Findings included: - During initial tour on 03/10/25 at 07:10 AM a medication cart on the 300 hallway was unlocked and unattended in the hallway. The unattended medication cart contained five opened, undated insulin (hormone that lowers the level of glucose in the blood) pens. On 03/10/25 at 07:59 AM on hall 300 a medication cart with scheduled medication, scheduled narcotics, nasal sprays, was left unlocked with the medication keys and narcotic keys left in the cart. On 03/10/25 at 09:20 AM a medication cart in the resident's quiet room was unlocked and unattended. The medication cart contained eye drops, skin creams, enemas and pain relieve cream. On 03/12/25 at 12:17 PM, Certified Medication Aide (CMA) R stated the medication cart should never be left unlocked and unattended. CMA R stated the keys should never be left in the lock on the medication cart and left unattended. On 03/12/25 at 12:42 PM, Licensed Nurse (LN) G stated the medication carts should not be left unlocked and unattended. LN G stated the keys should never be left in the lock of the medication unattended. LN G stated an insulin pen should be labeled at the time of the first administration. On 03/12/25 at 01:29 PM, Administrative Nurse D stated she expected all medication carts to be locked when unattended. Administrative Nurse D stated the keys should never be left in the lock of the medication cart and then left unattended. Administrative Nurse D stated she expected insulin pens to be label and dated. The facility was unable to provide a policy related medication storage. The facility failed to properly to store and label medications. This deficient practice could potentially cause adverse consequences or ineffective treatment to the affected residents.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 45668 The facility reported a census of 81 residents. The sample included 21 residents. Based on record review and interviews, the facility failed to submit accurate staffing information to the federal regulatory agency through Payroll Based Journaling (PBJ - Staffing Data Report), when the facility failed to submit accurate weekend staffing coverage hours. This placed the residents at risk for unidentified and ongoing inadequate staffing. Findings included: - A review of the facility's submitted PBJ data from 10/01/24 through 12/31/24 indicated the facility triggered for excessively low weekend staffing for Fiscal Year (FY) Quarter One 2025. On 03/12/25 at 10:00 AM, the facility's Resident Council reported staffing on the weekends consistently changed due to call-offs. The council indicated the weekend manager would come in to fill shifts and help fill in the gaps. A review of the facility's working schedule, time sheets/punches, and posted staffing hours indicated no gaps or loss of hours. An inspection of the working schedule revealed weekend call-offs documented with administrative nurse coverage. On 03/12/25 at 11:34 AM, Certified Medication Aide (CMA) R stated the facility had call-offs at times but would often have weekend managers to come in and either find replacements or work. On 03/12/25 at 01:30 PM, Administrative Nurse D stated the facility did have a lot of call-offs recently due to the influenza (contagious viral infection) outbreak. She stated the nurse managers came in to work and their time was not added to the PBJ submission. The facility was unable to provide a policy related to staffing or PBJ reporting as requested on 03/12/25. The facility failed to ensure accurate staffing hour information was submitted to the federal regulatory agency through PBJ when the facility failed to submit accurate weekend staffing coverage hours. This placed the residents at risk for unidentified and ongoing inadequate staffing.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 49634 The facility identified a census of 81 residents. The facility identified seven residents on Enhanced Barrier Precautions (EBP - infection control interventions designed to reduce transmission of resistant organisms that employ targeted gown and glove use during high contact care) and one person on contact precautions (safeguards designed to reduce the risk of transmission of microorganisms by direct or indirect contact). Based on record reviews, observations, and interviews, the facility failed to ensure to Resident (R) 130's Foley catheter (a tube inserted into the bladder to drain urine into a collection bag) tubing was off the floor. The facility additionally failed to store R38 respiratory equipment in a sanitary manner. The facility further failed to sanitize a shared Hoyer (total body mechanical lift) between residents and failed to ensure the clean linen was covered in a sanitary manner when going through residents' halls. These deficient practices placed the residents at risk for infectious diseases. Included Findings: - On 03/10/25 at 07:04 AM a walkthrough of the facility was completed. An inspection of R38's room revealed a nasal oxygen tubing wrapped around the back wheelchair handle, R38's nasal tubing was not stored in a sanitary manner. On 03/10/25 at 09:32 AM after transferring R38 with Hoyer lift Certified Nurse's Aide (CNA) M pushed the Hoyer to the residents quit room and walked away, CNA M did not sanitize the Hoyer lift after R38's transfer. On 03/11/25 at 09:28 AM a laundry personal pushed clean linen down hall 100, and then down 200 halls, the laundry cart had clean towels, the laundry cart was not covered in a sanitary manner. On 03/11/25 at 11:38 AM R130's Foley catheter tubing laid directly on the floor. R130's urinary bag was coved with a privacy bag and laid directly on the floor. On 03/12/24 at 12:17 PM, Certified Medication Aide (CMA) R stated all oxygen tubing and equipment should be stored in a clean plastic bag to prevent contamination and respiratory infections. She stated Hoyer should be wiped down, and wipes were stored in the medication room. CMA R stated clean linen should be covered when going down hallways. She stated the Foley catheter and tubing should be off the floor. On 03/12/25 at 12:41 PM, Licensed Nurse (LN) G stated all shared equipment should be sanitized between residents. She stated residents have bags to place all respiratory equipment in when not in use. LNG stated linen should always be covered, and the Foley catheter bag and tubing should be off the floor. On 03/12/25 at 01:30 PM, Administrative Nurse D stated linens should be covered when going through hallways, and the Hoyer should be sanitized between resident use. Foley catheters bags and tubing should never be on the floor, and all residents have bags in their rooms or hanging from there canisters to place oxygen tubing when not in use. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Infection Control policy dated 11/01/17 documented The facility's infection control polices and practices were intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections. The facility failed to ensure to R130's Foley catheter and tubing was off the floor. The facility additionally failed to store R38 respiratory equipment in a sanitary manner. The facility further failed to sanitize a shared Hoyer between residents and failed to ensure the clean linen was covered in a sanitary manner when going through residents' halls. These deficient practices placed the residents at risk for infectious diseases.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 41037 The facility identified a census of 81 residents. The sample included 21 residents, with five reviewed for immunization status. Based on record reviews, and interviews, the facility failed to offer or obtain informed declinations, consent, or a physician-documented contraindication for the Pneumococcal Conjugate Vaccine (PCV20- vaccination for bacterial infections) pneumococcal (type of bacterial infection) vaccination for Resident (R) 32. The facility also failed to administer PCV20 for R54 who had given consent. This placed these residents at increased risk for acquiring, transmitting, or experiencing complications from the pneumococcal disease. Findings included: - Review of R32's clinical record lacked documentation the PCV20 was offered or declined and lacked documentation of a historical administration or physician-documented contraindication. Review of R54's clinical record revealed the PCV13 was administered on 11/15/20. The facility provided a signed consent for PCV20 dated 10/02/24. R54's clinical record lacked documentation PCV20 was administered. On 03/12/25 at 12:42 PM, Licensed Nurse (LN) G stated she would ask the resident at the time of admission about their immunizations. LN G stated she was not responsible with tracking immunizations. On 03/12/25 at 01:29 PM, Administrative Nurse D stated the residents were asked at the time of admission about what immunizations they had received historically. Administrative Nurse D stated the Infection Preventionist was responsible to track and administer the immunizations. Administrative Nurse D stated R54's PCV20 had been overlooked and was ordered from the pharmacy. The facility's Pneumonia Vaccination Policy dated 11/28/16 documented the pneumococcal vaccination was offered to all patients and residents that meet eligibility criteria in accordance with current best practice clinical guidelines such as those from the Centers for Disease Control and Prevention (CDC). The facility failed to offer and administer PCV20 or obtain informed declinations for R32, who were eligible to receive the vaccination. The facility also failed to administer PCV20 after a consent was given for R54 on 10/02/24. This placed R32 and R54 at increased risk for acquiring, transmitting, or experiencing complications from the pneumococcal disease.