STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175214	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Diversicare of Chanute	530 W 14th Street Chanute, KS 66720

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41121 The facility reported a census of 49 residents with five residents reviewed including three residents reviewed for respiratory services. Based on observation, record review, and interview, the facility failed to administer the physician ordered amount of oxygen to Resident (R)5 and failed to ensure R1's oxygen tank did not run empty and/or was delivering oxygen as prescribed by the physician. Findings included: - The medical diagnosis tab for R5 included a diagnosis of chronic obstructive pulmonary disease (COPD- progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). The Significant Change Minimum Data Set, dated dated dated [DATE] assessed Resident (R)5 with a Brief Interview of Mental Status (BIMS) score of 12, indicating moderate cognitive impairment and required oxygen while a resident. The Care Plan initiated on 12/15/23 revealed the staff were to administer oxygen to R5 as needed, per the physician order, and to observe the flow rate and response. The Physician Orders tab in the electronic medical record (EMR) included an order dated 01/03/24 for oxygen at three liters continuously via nasal cannula related to COPD. On 03/19/24 at 05:03 PM, observed R5 resting in bed, oxygen in place via a nasal cannula and connected to the oxygen concentrator, with the setting between 3.5 - 4.0 liters. On 03/21/24 at 10:16 AM, observed R5 sitting in her wheelchair in her room with oxygen in place via a nasal cannula and connected to the oxygen concentrator, with the setting between 3.5 to 4.0 liters. On 03/21/24 at 03:26 PM, R5 stated her oxygen usually was set at three liters but thought the day before yesterday it was moved to four because she felt low on air. On 03/21/24 at 03:27 PM, observed R5's oxygen setting to be between 3.5 - 4.0 liters via the oxygen concentrator while in her room. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/21/24 at 03:26 PM, Licensed Nurse (LN) H stated R5's oxygen was to be set at four liters, she has COPD and cannot hardly breathe at all. LN H stated she does not look at oxygen orders everyday unless there was a change and R5's oxygen order used to be at two to four liters. LN H stated she had not been told there was a change in R5's orders so she had not looked. LN H stated the other day, she increased the oxygen to four liters due to R5 feeling short of air. LN H looked up R5's orders in the EMR and stated R5 had orders for the oxygen to be at three liters per minute. On 03/21/24 at 04:39 PM, Administrative Nurse D stated the staff should follow physician orders for administering oxygen and if the oxygen needs increased the staff should get an order from the doctor if there is no order range to titrate. The facility policy Oxygen Guideline dated 01/01/22 revealed oxygen would be provided in accordance to a physician's order including the dose/rate of administration. The facility failed to provide oxygen as ordered for R5. - The Medical Diagnosis tab in the electronic health record (EMR) for Resident (R)1 included diagnoses of acute respiratory failure with hypoxia (inadequate supply of oxygen) and heart failure. The Admission Minimum Data Set (MDS), dated [DATE] assessed R1 with a Brief Interview of Mental Status (BIMS) score of five, indicating severe cognitive impairment and did not require oxygen while a resident. The Quarterly MDS dated [DATE] assessed R1 with a BIMS score of eight, indicating moderate cognitive impairment and required oxygen while a resident. The Care Plan dated 12/21/23, revealed R1 had an alteration in his respiratory status due to congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid) and recent hospitalization for respiratory failure. The staff were to administer oxygen as needed per physician order and observe oxygen saturations (percentage of oxygen in the blood) on room air and/or oxygen and observe oxygen flow rate and response. The Physician Order tab in the electronic medical record (EMR) for R1 revealed an order dated 12/28/23 for oxygen at two liters per minute via a nasal cannula as needed to maintain oxygen saturation level above 90 percent, every shift, for respiratory failure. The cardiology physician Office Letter for R1's visit on 01/17/24 revealed upon arrival to the physician office, R1's oxygen tank was empty and R1's oxygen saturation level was 80 percent and R1 was a bit labored (trouble breathing). R1 complained of feeling very tired and weak. R1's oxygen saturation level was 80 percent upon arrival when the tank was empty. After R1 was on oxygen, he appeared more comfortable and was no longer hypoxic. The physician Office and Clinic Notes dated 03/15/24 revealed R1 had been wearing oxygen via a nasal cannula at three liters for some time secondary to hypoxia, when off oxygen, his oxygen saturation levels were below 86 percent on average. On 03/19/24 at 09:03 AM, observed R1 sitting up in his room in a wheelchair and had oxygen in place via the oxygen concentrator. R1's oxygen was set at 4.5 liters. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/19/24 at 09:05 AM, R1 stated he thought the oxygen was set on 3.5 liters. R1 stated the other day when he was in his room he had no air and the bottle was out of oxygen, it runs out a lot and that he was on the big one now so his oxygen was okay. R1 stated when he uses the bottle and it runs out, the staff does not get in in hurry to replace it. On 03/19/24 at 10:18 AM, R1's family member provided document which revealed he visited R1 nearly every day and nine times out of ten when arriving, there is no oxygen in the bottle. On 03/19/24 at 10:26 AM, R1's family member stated when talking to the facility about the oxygen bottle being empty, he was told there must be something wrong with the regulators. The family member stated R1 had a physician appointment on 03/15/24, and the oxygen bottle was empty when R1 arrived for the appointment, and the nurse had to hook him up to oxygen right away. On 03/19/24 at 12:13 PM, observed R1 sitting up in his wheelchair in the dining room feeding himself lunch. The oxygen in place per portable bottle at three liters. On 03/19/24 at 02:03 PM, Administrative Staff A stated on 03/16/24, R1's son voiced a concern of R1 being in his room and connected to the oxygen bottle, which was empty rather than the concentrator, and when at the doctor's office on 03/15/24, his oxygen ran out. Administrative Staff A stated on 03/15/24, transportation staff had called and said they needed a tank when they got back to the facility and when they pulled up to the facility, there was oxygen in the tank, the regulator was not turned all the way off, and you could hear the oxygen in it, the tank regulator showed the oxygen was low but not empty. Administrative Staff A stated he helped to change the oxygen bottle when R1 arrived back to the facility. On 03/19/24 at 02:18 PM, Licensed Nurse (LN) G stated on 03/16/24 after he took R1 to his room, his son who came in later came up to him and had said R1 had no oxygen and when he walked in to R1's room, the son told him he had taken care of it. LN G stated R1 was on the portable bottle, and he connected R1 to the oxygen concentrator. LN G stated R1 had the nasal cannula in his nose when he assisted him to his room and when he returned to the room. LN G stated R1 does have a habit of pulling the nasal cannula off to see if it was working. On 03/19/24 at 03:38 PM, Certified Medication Aide (CMA) R stated R1 often returned back from dialysis with an empty oxygen bottle, or the bottle would not be empty but needed the key to turn it on. CMA R stated the oxygen setting would be on, but the portable bottle was not turned on with the key so the oxygen could be delivered. CMA R stated at the time when he would return, she would go to shut the oxygen off, however, the oxygen was not turned on. CMA R stated at times, the piece that needed to be popped off before turning on, which would be in place on new oxygen bottles, would still be in place. On 03/21/24 at 11:16 AM, Consultant Staff HH stated she would have the office manager handle questions about R1's appointment on 03/15/24. On 03/21/24 at 11:39 AM, Consultant Staff GG stated she spoke with Consultant Staff HH who roomed R1 for his appointment on 03/15/24. When Consultant Staff HH was getting R1's vital signs, his oxygen saturation was low at 86 percent, and when looking at the oxygen bottle, the regulator showed it was in the red. Consultant Staff HH asked the family member that was there if the tank was on, and it was empty. After oxygen applied at three liters, R1's saturations increased to 93 percent. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/21/24 at 03:40 PM, Maintenance Staff U stated he took R1 to his appointment on 03/15/24 and stated he did not look at his oxygen bottle, he does not touch the oxygen, the aides get the resident ready and he takes them to the van. Maintenance Staff U stated R1's oxygen bottle regulator needle was in the red but not all the way. On 03/21/24 at 04:39 PM, Administrative Nurse D stated the staff should follow physician orders for oxygen. Administrative Nurse D stated the staff getting the resident ready for appointments should ensure the resident had enough oxygen and if the resident is leaving the building, they should have a new bottle. Administrative Nurse D stated the van should have an extra bottle of oxygen in there. The facility policy Oxygen Guidelines dated 01/01/22, revealed oxygen will be provided in accordance to a physician's order including dose/rate of administration. The facility failed to ensure R1 received oxygen per physician order.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41121 The facility reported a census of 49 residents with five residents selected for review, including one reviewed for medication errors. Based on interview and record review, the facility failed to start a physician ordered medication for Resident (R)1, that resulted in 22 days without the ordered medication. Findings included: - The Medical Diagnosis tab in Resident (R)1's electronic medical record (EMR) included diagnoses of atrial fibrillation (rapid, irregular heartbeat) and dependence on renal (kidney) dialysis (procedure where impurities or wastes were removed from the blood). The Quarterly Minimum Data Set, dated dated dated [DATE] revealed R1 did not take an anticoagulant medication (medication used to thin the blood to prevent clot formation). The Cardio-Kidney Vascular Care Ellipsys [minimally invasive procedure creating a fistula for dialysis] Discharge Instructions dated 02/22/24, revealed R1 was to take regular medicine including the blood thinner. The instructions included the Procedure Room - Medication Reconciliation form which included an order for apixaban (Eliquis - anticoagulant medication), five milligrams (mg), oral tablet, twice a day. The instructions lacked the facility had noted the orders. The cardiologist Office Letter dated 01/17/24 revealed R1 was to be having a fistula placed and needed to start Eliquis after implantation. The physician requested to be contacted after the date of the fistula implantation would be done so the Eliquis could be initiated. The physician Office and Clinic Notes dated 03/15/24 revealed R1 was supposed to be on Eliquis, 2.5 mg, twice daily for cardiology in atrial fibrillation had stopped due to fistula formation, however, needs to be restarted. The Miscellaneous tab in the EMR under the physician order section revealed a physician written script dated 03/15/24 for Eliquis, 2.5 mg, twice daily, for atrial fibrillation. The Medication Administration Record (MAR) dated February 2024, lacked instructions for the staff to administer apixaban. The MAR dated March 2024 lacked instructions for the staff to administer apixaban until 03/15/24. The staff administered the medication on 03/16/24 (23 days after the initial order on 02/22/24). The Progress Notes dated 02/13/24 revealed R1 had an appointment on 02/22/24 at 01:30 PM for fistula placement for dialysis. The Progress Notes dated 02/22/24 revealed R1 left the facility for appointment and returned to facility the same day with a dressing to R1's right arm. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Progress Notes dated 02/13/24 through 03/14/24 lacked documentation the facility notified the cardiology physician regarding the fistula placement and restarting the Eliquis. On 03/19/24 at 10:26 AM, R1's family member stated after the fistula was placed, R1 was to start back on the Eliquis. R1's family member stated R1 had a follow up appointment on 03/05/24 and he received three phone calls questioning if the Eliquis had been restarted and he referred the caller to the facility. R1's family member stated when R1 had appointment with his physician on 03/15/24 the Eliquis was not on the medication list and the physician stated R1 was to be back on the Eliquis. The family member stated the facility started the Eliquis on 03/16/24. On 03/21/24 at 11:39 AM, Consultant Staff GG stated R1 did not have Eliquis on the medication list provided at the 03/15/24 appointment, and the dose ordered was according to the cardiologist office notes on 01/17/24. On 03/21/24 at 01:19 PM, Administrative Nurse D stated the facility did not have R1's appointment notes from 01/17/24 and had to request them. Administrative Nurse D stated she was not aware of the medication error with the Eliquis until 03/18/24 and R1 should have started the Eliquis after the fistula placement. Administrative Nurse D stated when a resident returns to the facility, the charge nurse at that time should take care of the orders, then medical records staff was to ensure the orders were noted before scanning in the EMR. The medical records staff was to bring any new orders to the morning meeting. Administrative Nurse D stated she did not recall seeing the orders from the procedure on 02/22/24, however, she had been working on the floor also and was not at every morning meeting. The facility lacked a policy for following physician orders. The facility failed to notify the cardiologist of the fistula appointment for instructions on restarting the Eliquis and failed to initiate the Eliquis ordered on 02/22/4 until 03/16/24, 23 days later after the initial order.