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	06/25/2024

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 0684 Level of Harm - 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** 41121 The facility reported a census of 46 residents with four residents selected for review, including three residents reviewed for skin conditions. Based on observation, interview, and record review, the facility failed to ensure one of the three residents, Resident (R)1, had clean and dry dressings to his lower extremities. On 06/17/24, at an appointment, Consultant Staff GG discovered two maggots on R1's right lower extremity while removing urine and fluid-soaked dressings due to weeping from his right lower extremity. The dressings removed were dated 06/13/24, four days prior, when Consultant Staff GG applied the lymphedema wraps (compression wraps used to try and reduce swelling caused by accumulation of lymph). R1 reported concerns about his wraps to Licensed Nurse (LN) I on 06/16/24 between 10:00 PM to 11:00 PM, and LN I told R1 his wound appointment was scheduled for the next morning. R1's dressings remained in place until his appointment time on 06/17/24 at 01:00 PM, 14-15 hours after R1 voiced his concerns about his dressings. R1 lacked any additional orders to instruct the staff what to do should his dressings become soiled, wet, or loose. Findings included: - The Medical Diagnosis tab for R1 included diagnosis of lymphedema (swelling caused by accumulation of lymph), venous insufficiency (poor circulation), and cellulitis (skin infection caused by bacteria) of the right lower extremity. The Admission Minimum Data Set, dated dated dated [DATE], assessed R1 with a Brief Interview of Mental Status score of 15, which indicated he had intact cognition. R1 did not reject cares and was continent of urine. R1 had an infection of his foot, moisture associated skin damage (MASD). R1 had dressings applied to his feet, nonsurgical dressing applied other than to feet, and ointments/medications applied other than to feet. The Functional Abilities Care Area assessment dated [DATE], revealed R1 required assistance with his activities of daily living (ADL's), had increased weakness, and was at risk for skin breakdown, incontinence, and further ADL decline. The Dehydration/Fluid Maintenance CAA dated 03/25/24, revealed R1 admitted to the facility with cellulitis and prescribed two antibiotics to treat the cellulitis. R1 had a chronic wound on his right leg with Ace wraps (elastic bandage) daily and wound treatments to his wound. R1 had risk factors of impaired fluid balance and impaired skin integrity. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The Pressure Ulcer/Injury CAA dated 03/25/24, revealed the staff were to notify R1's physician of any abnormal findings and treatment orders. The Care Plan dated 04/11/24 revealed R1 had cellulitis to his right lower extremity and the infection would resolve without complication. R1 was to have elastic bandage wraps applied to bilateral (both) lower extremities in the am and taken off at hour of sleep. The staff were to administer antibiotics as ordered and follow wound treatment orders. The Skin and Wound Evaluation revealed on 06/11/24, R1 had a blister to his front left lower leg and had areas of weeping to his right calf in three different areas that were not open. On 06/19/24, R1 had a new blister to his left calf. The Physician Orders tab included an order for R1, dated 06/14/24 to keep lymphedema wraps to his bilateral lower extremities clean, dry, and intact. Outpatient therapy were to change the dressings on Monday, Wednesday, and Friday. Staff were to monitor the wraps twice daily during the 06:00 AM to 06:00 PM shift and the 06:00 PM and the 06:00 AM shift. The Treatment Administration Record (TAR) dated June 2024, revealed the resident's wraps were clean, dry, and intact on 06/14/24 for the 06:00 PM shift, 06/15/24 for the 06:00 AM and PM shift, and on 06/16/24 for the PM shift. On 06/16/24 for the 06:00 AM shift, the staff documented a 7 indicating to Other/See Progress Note. The Progress Note dated 06/13/24 at 09:42 AM, revealed R1 returned from his appointment at the outpatient clinic with new orders, and his next appointment was on 06/17/24 at 01:00 PM. The Progress Note dated 06/16/24 at 10:42 AM, an order administration note for R1, lacked documentation for the reason on the TAR to be charted as Other/See Progress Notes as to why the wraps may not be clean/dry/intact. The Progress Note dated 06/17/24 at 01:11 PM, revealed R1 left the facility for his appointment at the wound clinic. The Progress Note dated 06/17/24 at 02:02 PM, revealed R1 returned from his appointment at the wound clinic with no new orders. The note lacked documentation regarding maggots. The Progress Note dated 06/22/24 at 01:39 PM, revealed R1 removed his wraps this morning due to them being soaked with urine, which was a frequent occurrence with him, saturating his wraps and pants with urine. On 06/24/24 at 07:55 AM, observed R1 in his room in a recliner. His feet rested on a folded-up towel which was directly on the floor. A tied-up plastic bag sat on the floor, and next to the towel, his feet were on a pile of wraps and gauze. R1's left leg had gauze wrapped around it from above his ankle to below his knee and his right leg had gauze wrapped from the base of his toes to below his knee and was loose at the top with abdominal gauze pads (ABD pads - highly absorbent dressing) in place. The gauze wraps on the right lower leg were almost entirely yellow in color from drainage. R1 had a flyswatter in his room and killed one live fly and two others were observed in the room and landed on the dressings piled directly on the floor. There was a prominent foul odor in his room. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 06/24/24 at 07:57 AM, R1 stated he was told by LN H not to leave wet soiled wrappings on his leg and R 1 removed them at 06:00 AM. He informed the off-going CNA M and CNA N, and CNA N placed a towel on the floor for R1 to rest his feet on. R1 stated while at the (outpatient clinic for wound management), two maggots were found under his dressing. R1 stated staff were to change his dressing daily, but the dressing did not get changed yesterday. R1 stated he wished LN H would have changed them yesterday and further stated he had staff ask her about it but she had already gone home. R1 stated last week there were four days the dressings did not get changed as Administrative Nurse D said not to change or touch the wraps. R1 stated he was finally able to get staff to remove the plastic thing off of the toilet (referred to device in bathroom with elevated seat and handles that sits over the toilet) as it was causing urine to run down and get in his wraps. On 06/24/24 at 08:20 AM, LN G stated she did not think she had to do anything with R1's wraps, as he was scheduled to go today to the wound clinic, and she had not seen his legs yet today for her shift. LN G stated in shift change report, she was told R1's wraps were getting changed at there (outpatient clinic for wound care), and she was not able to change those due to lack of certification to apply the lymphedema wraps. LN G stated the wraps were to be changed on Monday, Wednesday, and Friday by outpatient therapy and prior to that, the facility nurses changed the dressings daily. LN G stated R1 removed the wraps a lot because they would get wet. LN G looked at the pile of wraps on the floor and they were dated for 06/22/24 and initialed by LN H. LN G left the pile of wraps and gauze on the floor and exited the room. On 06/24/24 at 08:54 AM, LN G asked Administrative Nurse D what to do with R1's legs. Administrative Nurse D stated she needed to find R1's order sheet, as she thought the outpatient therapy center sent back instructions on what to do. The Progress Note dated 06/24/24 at 09:01 AM, revealed Administrative Nurse D spoke with outpatient therapy on what treatment needed done when R1's wraps became soiled and the staff stated, Leave them off today and we will talk to him about removing them himself and will send orders back for what to replace wraps with when they become soiled. The note revealed nursing staff were notified. On 06/24/24 at 09:09 AM, LN G picked up the wraps and dressings off the floor in R1's room and removed part of the gauze wraps from his legs then exited the room. On 06/24/24 at 09:11 AM, LN G stated there was not an order for R1 if his wraps were not clean/dry/intact and Administrative Nurse D was going to request one. LN G stated what had been on R1's legs on 06/22/24 was the treatment that was being done before, and R1 should have an order on what to do in between times if the wraps were not clean/dry/intact. LN G stated she would clean R1's legs after he finished eating, and she left the current drainage covered gauze wraps in place to his right lower extremity and the gauze wraps remained on his left lower extremity. On 06/24/24 at 10:16 AM, LN G stated she did not have a treatment order for R1's legs yet. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 06/24/24 at 10:34 AM, LN G stated she was going to take the rest of the wraps off of R1's legs and clean them and did not have an order yet for any dressings. R1 was sitting in his recliner in his room. LN G placed the packaged gauze directly on the nightstand along with tape cut in pieces to secure the gauze. After removing the dressings, LN G began to clean R1's legs with the same contaminated gloves used to remove the soiled dressings. When the surveyor questioned if a new pair of gloves should be in place, LN G stated, It's dirty too and removed the gloves and applied a new pair without performing hand hygiene. Then, LN G placed four by four-inch gauze pads directly on R1's overbed table and used a gloved hand to open the nightstand drawer and removed more four -inch gauze pads out of the drawer and placed them directly on the overbed table. These treatment supplies were used to wipe R1's legs after LN G sprayed them with wound cleanser. R1 had an ABD pad which was stuck to his left lower extremity and required LN G to spray wound cleanser on to loosen the ABD pad from his leg. There was a live fly observed in R1's room during the process. LN G stated she was going to check with Administrative Nurse E to see if she wanted to take pictures of R1's legs and exited the room. R1's legs were noted to have redness, scaling, and edema. The left leg had a small scab to shin area and was not able to visualize the back of his legs. On 06/24/24 at 10:55 AM, LN G stated Administrative Nurse E wanted to take pictures of R1's legs but was assisting another resident at the time. LN G stated Administrative E told her to wrap his legs with Kerlix (gauze rolls which can be used to absorb wound drainage and hold dressings in place) because they were weeping. On 06/24/24 at 11:24 AM, entered R1's room with LN G and observed an area of fluid on the floor next to the towel R1 had his feet on. LN G stated that was from R1's legs it just runs. LN G retrieved a roll of gauze from the drawer in R1's nightstand, not packaged, sprayed R1's legs with a wound cleanser, and used the gauze wrap to wipe R1's legs. LN G then removed her gloves and applied a new pair without performing hand hygiene. LN G moved the packaged gauze wraps and strips of tape to R1's bed along with scissors without a barrier. LN G moved a trash can on its side and used the towel under R1's feet that was on the floor and placed it on the trash can, then R1's right foot on top of the towel that had been on the floor. LN G then began using gauze rolls to wrap R1's legs and during that time drips of fluid were coming from the back of his right leg. Once LN G finished wrapping the right leg, she placed his left foot directly on the trash can and removed her gloves. LN G stated she would be right back she needed to get more gauze. LN G returned and applied gloves then stated she forgot to grab socks, so she exited R1's room while removing the gloves at 11:36 AM without disposing gloves or performing hand hygiene before exiting the room On 06/24/24 at 11:38 AM, LN G returned to R1's room with socks, applied gloves, and placed a sock on R1's right foot. LN G stated, It is leaking already and applied another layer of gauze to R1's right leg. LN G placed R1's left heel back on the trash can and applied one roll of gauze. While she went to grab another roll, the end of the applied roll fell down and touched the surface of the trash can. LN G reapplied the end of the gauze roll that touched the trash can and began wrapping R1's left leg with the second roll. After securing with gauze with tape and after she applied a sock to his left foot, LN G exited the room at 11:47 AM with her gloved hands, tied up the trash and the linen bag, scissors, wound cleanser, and the stool she [NAME] in to sit on while she performed dressing cares. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 06/24/24 at 12:36 PM, Housekeeping Staff U stated the only issues with flies she had seen in the facility was in R1's room, which she thought was due to his legs that leaked fluids which smelled like rotten eggs. Housekeeping Staff U stated when she was in there yesterday his bandages were soaked through. When asked what was done about the flies in R1's room Housekeeping Staff U stated, I don't have a fly swatter and she had not killed any in his room. On 06/24/24 at 12:46 PM, LN G stated she had not seen any maggots on R1's skin or dressings but received in report one day they were found at the center where his wraps were done. On 06/24/24 at 12:54 PM, LN H stated she heard R1 had maggots in his leg dressings from R1 and LN J on one of the days he went to the clinic. LN H stated on 06/22/25, R1 removed his wraps, and his legs were weeping fluid all over the floor, so she applied wraps. LN H stated R1 told her the clinic said to remove the wraps when they became soaking wet. LN H stated she re-wrapped his legs because they were open to air and fluid leaked all over the floor. LN H stated she was not aware of what the clinic advised as there was not any paperwork received from them. LN H stated on 06/23/24, R1 had some wetness by the ankle and up a little bit and did not do anything with the dressings and left them in place through the end of her shift at 06:00 PM. On 06/24/24 at 01:06 PM, LN J stated R1 told her that last week when returning from the clinic they (clinic staff) found maggots. She verified there have been flies in his room, and thought he had a fly swatter in his room. LN J stated she had not killed any flies in his room and seemed like that was the only room that had them. LN J stated the clinic (where wraps are done) usually does not send paperwork back from his appointments. LN J stated Administrative Nurse D kept tracks of resident wounds. On 06/24/21 at 01:11 PM, Administrative Nurse E stated R1 returned from the center where his wraps are done and reported maggots were found, so she called the center to clarify what he had said. Administrative Nurse E stated she was told by Consultant Staff GG on 06/17/24 of two maggots found and had not seen any on 06/14/24. Administrative Nurse E stated hand hygiene should be performed during dressing changes and before going in a resident's room, gloves should be removed after taking off dressings and hand hygiene should be performed before applying new gloves. Administrative Nurse E stated staff should place a barrier between the dressing supplies and the surface placed on. Administrative Nurse E stated a trash can should not be used to prop his foot/leg up on for the dressing change and if any part of the dressing touched the trash can surface, it should be disposed of. Administrative Nurse E stated if the dressings are loose, the nursing staff should address that as soon as they see it and should use a clean towel under his feet before doing his dressing changes. Gloved hands should not be used to gather supplies from the nightstand drawer. If R1's dressings were leaking, then the nursing staff should try to address it even if just reinforcing them and should call the doctor at any time to get an order, as he was the one that ordered the wraps. Administrative Staff A stated the staff should clean/sanitize the floor where the wraps were in contact with. On 06/24/24 at 02:00 PM, LN G stated during the weekend of 06/15/24 and 06/16/24, during her day shift (06:00 AM to 06:00 PM) R1's legs were not leaking, and she did not do any treatments to R1's legs. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 06/24/24 at 02:37 PM, Consultant Staff GG stated she had been doing the lymphedema wraps and when R 1 came in on 06/13/24, his wraps were soiled. When R1 came in on 06/17/24 his wraps were soiled with urine and his legs weep a lot. The dressings in place were dated 06/13/24 and were the ones she had placed on that day when she evaluated him. When she was unwrapping R1's right leg on 06/17/24, she observed a maggot toward the top of his leg and one on his ankle. Consultant Staff GG stated she told R1 to keep the bandages on unless soiled then to take them off. Consultant GG stated she did not call the facility right away regarding the maggots as she had another patient and Administrative Nurse E had called her and she gave Administrative Nurse E instructions on keeping the wraps on and clean unless they became soiled. Consultant Staff GG stated she would have expected R1 to arrive with cleaner dressings on than he did on 06/17/24 and not the ones from 06/13/24. Consultant Staff GG stated she had made contact with the facility almost every visit she had seen R1. On 06/24/24 at 02:59 PM, Administrative Nurse D stated R1 went for an evaluation on 06/13/24 and they received the treatment orders on 06/14/24 from the clinic. Administrative Nurse D stated the nurse should call if wraps were soiled to get a treatment order. On 06/24/24 at 04:17 PM, LN I stated he took care of R1 on 06/14/24, 06/15/24, and 06/16/24 during the 06:00 PM to 06:00 AM shift and R1 had an order for lymphedema wraps on Monday, Wednesday, and Friday for therapy to perform the dressing changes. LN I stated he was told not to apply new wraps as he was not trained to change the wraps. LN I stated he looked at the wraps and on 06/16/24 they were not clean/dry/intact. LN I stated R1 had brought that to his attention around 10:00 PM or 11:00 PM and LN I told R1 the wraps would get changed in the morning. LN I stated he was not aware of any other orders in place when not clean/dry/intact. On 06/24/24 at 04:56 PM, Administrative Staff A stated, when asked what the facility had done to address the issue of maggots being found on R1's skin, he stated he was not aware of maggots being found until today (06/24/24) from one of the nurses after the surveyor's arrival on site. The facility's policy for Hand Hygiene Audit undated, revealed hand washing should be done every time staff remove gloves, before and after each resident contact, every time moving from a dirty to a clean area, and sanitizer could be used instead of soap and water when hands are lightly soiled without visible debris on hand. The facility's undated policy for Clean Dressing Change revealed to create a clean field using a towel or paper towels, open dressings, and place on first pair of gloves, remove soiled dressing, dispose of gloves, wash hands, apply a second pair of gloves, cleanse wound, remove gloves, wash hands/sanitize, and re-glove. After applying prescribed medication/dressing secure per order, remove gloves, and wash hands. The facility's policy for Notification of Patient/Resident Change dated 11/01/16, revealed the facility will consult the resident's physician, nurse practitioner or physician assistant when there is a need to alter treatment significantly (i.e., need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment). (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The facility failed to ensure R1 had clean/dry/intact dressings/wraps to his lower extremities and failed to contact the physician for orders when dressing were wet/soiled, which resulted in R1 going 14 - 15 hours from 06/16/24 to 06/17/24 when he had his appointment with outpatient therapy for his lymphedema wraps. On 06/17/24 at outpatient therapy, maggots were found on R1's skin when therapy staff removed his wet and soiled wraps dated 06/13/24. Additionally, the facility failed to ensure wraps were clean/dry/intact on 06/24/24 when R1 alerted staff regarding their condition at 06:00 AM. The staff removed the rest of the soiled dressings from his legs on 06/24/24 at 10:34 AM, more than four hours later. The facility failed to ensure R1 had an order in place for treatment to R1's legs if the wraps were not clean/dry/intact, placing R1 at risk for further skin impairment and further presence of maggots to areas requiring treatment.

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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 46 residents with four residents selected for review including three residents reviewed for following physician wound care orders. Based on observation, interview, and record review, the facility failed to ensure one of the residents, Resident (R)4, had the appropriate wound treatment provided. Findings included: - The Medical Diagnosis tab for R4 included diagnoses of need for assistance with personal cares, muscle weakness, and edema (swelling resulting from an excessive accumulation of fluid in the body tissues). The Significant Change Minimum Data Set (MDS) dated [DATE], assessed R4 with a Brief Interview of Mental Status (BIMS) score of 15, indicating intact cognition. R4 had frequent incontinence of bowel and bladder, moisture associated skin damage (MASD) and application of nonsurgical dressings and ointments/medications other than to feet. The Pressure Ulcer/Injury Care Area assessment dated [DATE], revealed R4 had MASD to buttocks and received ointment, and was incontinent of bowel and bladder. The Quarterly MDS dated [DATE], revealed R4 continued with a BIMS score of 15, was frequently incontinent of bowel and bladder and had MASD. The staff applied nonsurgical dressings and ointments/medications other than to feet. The Care Plan dated 04/26/24 revealed R4 was at high risk for pressure ulcer development related to her history of ulcers, immobility, and presence of moisture and had MASD on her right and left medial (middle) thigh and coccyx. The staff were to complete wound treatments as ordered. The Skin and Wound Evaluation dated 06/18/24 revealed R4 had the right and left medial thigh. The Physician Orders tab for R4 revealed an order dated 06/08/24 to apply Dermafoam (highly absorbent waterproof foam dressing) to bilateral (both) upper back thigh wounds PRN [as needed] soiled, in the morning. The Progress Note dated 06/08/24 at 10:25 AM, revealed R4 wounds measured, and a new treatment to bilateral leg wounds for Dermafoam over wounds and change as needed when soiled. On 06/24/24 at 02:10 PM, observation revealed Licensed Nurse (LN) G apply Dermaseptin to the back of R3's left and right thigh LN G failed to follow orders and applied an ointment instead of a foam dressing. On 06/24/24 at 02:12 PM, LN G stated she had never put foam on her before and had never seen foam on those wounds. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/24/24 at 02:20 PM, Administrative Nurse E stated per physician orders, the LN should apply Dermafoam to R4's upper thighs. Administrative Nurse E stated the Dermafoam should be in place at all times and change if soiled, the dressing was not a PRN dressing. On 06/24/24 at 02:28 PM, R4 stated the foam had been off since last night, time unknown, did not know if the nursing staff was aware or not, and usually has foam in place. R4 stated if the areas are really bothering her, she will ask for foam to be put on, which is usually when she sits up for too long. On 06/24/24 at 02:59 PM, Administrative Nurse D stated the LN should check the orders before doing the treatment, they need to know the exact steps, like a medication. On 06/24/24 at 04:17 PM, LN I, who had worked the night shift, stated he was not aware of any open areas that R4 had, she had a cream for her bottom, and could not recall a treatment to her thighs. The facility lacked a policy regarding following physician orders. The facility failed to follow physician orders and apply the physician ordered treatment to R4's two thigh wounds.

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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. 41121 The facility reported a census 46 with four residents selected for review including three residents reviewed for unnecessary medication. Based on observation, record review, and interview, the facility failed to monitor bowel functioning for one Resident (R)3 for constipation (difficulty passing stools) and contact the physician for orders to treat the constipation. Findings included: - The Medical Diagnosis tab for R3 included diagnoses of fracture (broken bone) of the shaft of the right fibula (one of the two bones of the lower leg) and need for assistance with personal care. The Minimum Data Set (MDS) tab revealed R3 entered the facility on 06/18/24, and the Admission MDS was in progress. The Baseline Care Plan dated 06/18/24, for R3 lacked any information filled in by the facility. The Care Plan initiated on 06/24/24, revealed R3 had a self-care deficit problem related to her fractured right leg and recent surgery and lacked any information regarding bowel function. The Clinical and Order Alerts Report dated 05/25/24 through 06/23/24, revealed R3 lacked having a bowel movement documented in three days. Review of the Licensed Medication Administration Record and Medication Administration Record from 06/18/24 to 06/24/24, lacked any medication for R3 for constipation. R3 received Ultram (pain medication) and Bumex (medication used to remove excess fluid), which both can contribute to constipation. Review of the Bowel Elimination task revealed R3 had a bowel movement on 06/19/24 and on 06/25/24. R3 lacked having a bowel movement for five days from 06/20/24 through 06/24/24. Review of the Progress Notes from 06/18/24 through 06/24/24 for R3 lacked documentation regarding constipation. The Daily Skilled Nurses Note under the Evaluation tab for R3 revealed on 06/22/24 (three days after the last bowel movement) and 06/23/24 (four days after the last bowel movement) she did not have constipation. Both skilled notes revealed R3 was alert and oriented to person, place, and time. The Evaluation tab lacked a Daily Skilled Nurses Note for 06/24/24. On 06/25/24 at 10:58 AM, observation revealed R3 sitting up in her room in a wheelchair with her right leg in a cast and elevated with the footrest on the wheelchair. A mechanical lift sling was under R3 in the wheelchair. Certified Nurse Aide (CNA) O was in her room and had emptied the commode. (continued on next page)

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	175214	A. Building B. Wing	06/25/2024

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Diversicare of Chanute	530 W 14th Street Chanute, KS 66720

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/25/24 at 11:00 AM, R3 stated she had a terrible time with constipation, which was not unusual for her to have that kind of trouble and stated she had not had a bowel movement since she had been in the facility, and she did not have one during the night. R3 stated at home she took Miralax (medication for constipation) and her bowel movements were more regular. R3 stated she did not know if the staff addressed her constipation but said they know about it. R3 stated she was not having any pain but a lot of gas. On 06/25/24 at 11:07 AM, Licensed Nurse (LN) G stated the process for bowel monitoring was the CNAs would report the bowel movement on their daily charting and the nurse would get a printout on the computer if the resident had not had a bowel movement in three days. LN G stated, people usually tell us if they need something. LN G stated by the third day if no bowel movement, then we give them something. LN G stated the facility has standing physician orders that can be activated if needed for constipation. LN G stated R3 had not been on the report for no bowel movement. LN G stated laxatives are given by the nurse who passes the medications and did not know if R3 received pain medication or not that could cause constipation. On 06/25/24 at 11:24 AM, Administrative Nurse D stated the process for bowel monitoring included the CNAs chart everyday whether a resident has had a bowel movement or not, then an alert is on the electronic charting if a resident has not had a bowel movement for three days, and the nurses are to address it. If a resident does not have an order for an as needed (PRN) medication for constipation, the staff were to contact the physician for orders, as the facility does not have standing orders. Administrative Nurse D stated the nurses were to address the no bowel movement alert before the end of their shift, and a lot of times night shift or herself would print out the list for the staff passing medications to administer a PRN for constipation. Administrative Nurse D recalled last Thursday (06/20/24) or Sunday (06/23/24) talking about her bowel function but was not aware if the doctor had been contacted or not. Administrative Nurse D stated anyone on pain medication should have a stool softener or something for their bowels. On 06/25/24 at 11:52 AM, CNA O stated she had assisted R3 at least three times with toileting and she had not had a bowel movement. CNA O stated R3 complained of constipation yesterday to her and she reported that to LN G. The facility policy Notification of Patient/Resident Change dated 11/01/16, revealed the center will consult the resident's physician, nurse practitioner or physician assistant when there is a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment). The facility failed to notify the physician when R3 went three days without having a bowel movement, resulting in five days from 06/20/24 through 06/24/24, without having a bowel movement.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41121 The facility reported a census of 46 residents. Based on observation, interview, and record review, the facility failed to maintain an effective infection prevention and control program with failure to perform appropriate hand hygiene and a clean dressing change procedure on 06/24/24, and to ensure Resident (R)1 had clean and dry dressings to his lower extremities. Findings included: - The Medical Diagnosis tab for R1 included diagnosis of lymphedema (swelling caused by accumulation of lymph), venous insufficiency (poor circulation), and cellulitis (skin infection caused by bacteria) of the right lower extremity. The Admission Minimum Data Set, dated dated dated [DATE], assessed R1 with a Brief Interview of Mental Status score of 15, which indicated he had intact cognition. R1 did not reject cares and was continent of urine. R1 had an infection of his foot, moisture associated skin damage (MASD). R1 had dressings applied to his feet, nonsurgical dressing applied other than to feet, and ointments/medications applied other than to feet. The Functional Abilities Care Area assessment dated [DATE], revealed R1 required assistance with his activities of daily living (ADL's), had increased weakness, and was at risk for skin breakdown, incontinence, and further ADL decline. The Dehydration/Fluid Maintenance CAA dated 03/25/24, revealed R1 admitted to the facility with cellulitis and prescribed two antibiotics to treat the cellulitis. R1 had a chronic wound on his right leg with Ace wraps (elastic bandage) daily and wound treatments to his wound. R1 had risk factors of impaired fluid balance and impaired skin integrity. The Pressure Ulcer/Injury CAA dated 03/25/24, revealed the staff were to notify R1's physician of any abnormal findings and treatment orders. The Care Plan dated 04/11/24 revealed R1 had cellulitis to his right lower extremity and the infection would resolve without complication. R1 was to have elastic bandage wraps applied to bilateral (both) lower extremities in the am and taken off at hour of sleep. The staff were to administer antibiotics as ordered and follow wound treatment orders. The Physician Orders tab included an order for R1, dated 06/14/24 to keep lymphedema wraps to his bilateral lower extremities clean, dry, and intact. Outpatient therapy were to change the dressings on Monday, Wednesday, and Friday. Staff were to monitor the wraps twice daily during the 06:00 AM to 06:00 PM shift and the 06:00 PM and the 06:00 AM shift. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/24/24 at 07:55 AM, observed R1 in his room in a recliner. His feet rested on a folded-up towel which was directly on the floor. A tied-up plastic bag sat on the floor, and next to the towel, his feet were on a pile of wraps and gauze. R1's left leg had gauze wrapped around it from above his ankle to below his knee and his right leg had gauze wrapped from the base of his toes to below his knee and was loose at the top with abdominal gauze pads (ABD pads - highly absorbent dressing) in place. The gauze wraps on the right lower leg were almost entirely yellow in color from drainage. R1 had a flyswatter in his room and killed one live fly and two others were observed in the room and landed on the dressings piled directly on the floor. There was a prominent foul odor in his room. On 06/24/24 at 08:20 AM, LN G looked at the pile of wraps on the floor and they were dated for 06/22/24 and initialed by LN H. LN G left the pile of wraps and gauze on the floor and exited the room. On 06/24/24 at 09:09 AM, LN G picked up the wraps and dressings off the floor in R1's room and removed part of the gauze wraps from his legs then exited the room. On 06/24/24 at 09:11 AM, LN G stated there was not an order for R1 if his wraps were not clean/dry/intact and Administrative Nurse D was going to request one. LN G stated what had been on R1's legs on 06/22/24 was the treatment that was being done before, and R1 should have an order on what to do in between times if the wraps were not clean/dry/intact. LN G stated she would clean R1's legs after he finished eating, and she left the current drainage covered gauze wraps in place to his right lower extremity and the gauze wraps remained on his left lower extremity. On 06/24/24 at 10:34 AM, LN G stated she was going to take the rest of the wraps off of R1's legs and clean them and did not have an order yet for any dressings. R1 was sitting in his recliner in his room. LN G placed the packaged gauze directly on the nightstand along with tape cut in pieces to secure the gauze. After removing the dressings, LN G began to clean R1's legs with the same contaminated gloves used to remove the soiled dressings. When the surveyor questioned if a new pair of gloves should be in place, LN G stated, It's dirty too and removed the gloves and applied a new pair without performing hand hygiene. Then, LN G placed four by four-inch gauze pads directly on R1's overbed table and used a gloved hand to open the nightstand drawer and removed more four -inch gauze pads out of the drawer and placed them directly on the overbed table. These treatment supplies were used to wipe R1's legs after LN G sprayed them with wound cleanser. R1 had an ABD pad which was stuck to his left lower extremity and required LN G to spray wound cleanser on to loosen the ABD pad from his leg. There was a live fly observed in R1's room during the process. LN G stated she was going to check with Administrative Nurse E to see if she wanted to take pictures of R1's legs and exited the room. R1's legs were noted to have redness, scaling, and edema. The left leg had a small scab to shin area and was not able to visualize the back of his legs. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/24/24 at 11:24 AM, entered R1's room with LN G and observed an area of fluid on the floor next to the towel R1 had his feet on. LN G stated that was from R1's legs it just runs. LN G retrieved a roll of gauze from the drawer in R1's nightstand, not packaged, sprayed R1's legs with a wound cleanser, and used the gauze wrap to wipe R1's legs. LN G then removed her gloves and applied a new pair without performing hand hygiene. LN G moved the packaged gauze wraps and strips of tape to R1's bed along with scissors without a barrier. LN G moved a trash can on its side and used the towel under R1's feet that was on the floor and placed it on the trash can, then R1's right foot on top of the towel that had been on the floor. LN G then began using gauze rolls to wrap R1's legs and during that time drips of fluid were coming from the back of his right leg. Once LN G finished wrapping the right leg, she placed his left foot directly on the trash can and removed her gloves. LN G stated she would be right back she needed to get more gauze. LN G returned and applied gloves then stated she forgot to grab socks, so she exited R1's room while removing the gloves at 11:36 AM without disposing gloves or performing hand hygiene before exiting the room On 06/24/24 at 11:38 AM, LN G returned to R1's room with socks, applied gloves, and placed a sock on R1's right foot. LN G stated, It is leaking already and applied another layer of gauze to R1's right leg. LN G placed R1's left heel back on the trash can and applied one roll of gauze. While she went to grab another roll, the end of the applied roll fell down and touched the surface of the trash can. LN G reapplied the end of the gauze roll that touched the trash can and began wrapping R1's left leg with the second roll. After securing with gauze with tape and after she applied a sock to his left foot, LN G exited the room at 11:47 AM with her gloved hands, tied up the trash and the linen bag, scissors, wound cleanser, and the stool she [NAME] in to sit on while she performed dressing cares. On 06/24/21 at 01:11 PM, Administrative Nurse E stated hand hygiene should be performed during dressing changes and before going in a resident's room, gloves should be removed after taking off dressings and hand hygiene should be performed before applying new gloves. Administrative Nurse E stated staff should place a barrier between the dressing supplies and the surface placed on. Administrative Nurse E stated a trash can should not be used to prop his foot/leg up on for the dressing change and if any part of the dressing touched the trash can surface, it should be disposed of. Administrative Nurse E stated if the dressings are loose, the nursing staff should address that as soon as they see it and should use a clean towel under his feet before doing his dressing changes. Gloved hands should not be used to gather supplies from the nightstand drawer. If R1's dressings were leaking, then the nursing staff should try to address it even if just reinforcing them and should call the doctor at any time to get an order, as he was the one that ordered the wraps. Administrative Staff A stated the staff should clean/sanitize the floor where the wraps were in contact with. The facility's policy for Hand Hygiene Audit undated, revealed hand washing should be done every time staff remove gloves, before and after each resident contact, every time moving from a dirty to a clean area, and sanitizer could be used instead of soap and water when hands are lightly soiled without visible debris on hand. The facility's undated policy for Clean Dressing Change revealed to create a clean field using a towel or paper towels, open dressings, and place on first pair of gloves, remove soiled dressing, dispose of gloves, wash hands, apply a second pair of gloves, cleanse wound, remove gloves, wash hands/sanitize, and re-glove. After applying prescribed medication/dressing secure per order, remove gloves, and wash hands. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to provide a safe and sanitary environment to help prevent the development and transmission of communicable diseases and infection while providing a clean dressing change to R1's lower extremities.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 41121 The facility reported a census of 46 residents. Based on observation, interview, and record review, the facility failed to maintain an effective pest control program. On 06/17/24, Resident (R)1 had an appointment where Consultant Staff GG discovered two maggots on R1's right lower extremity while removing urine and fluid-soaked dressings due to weeping from his right lower extremity. Findings included: - The Progress Note dated 06/17/24 at 01:11 PM, revealed R1 left the facility for his appointment at the wound clinic. The Progress Note dated 06/17/24 at 02:02 PM, revealed R1 returned from his appointment at the wound clinic with no new orders. The note lacked documentation regarding maggots. On 06/24/24 at 07:55 AM, observed R1 in his room in a recliner. His feet rested on a folded-up towel which was directly on the floor. A tied-up plastic bag sat on the floor next to a pile of wraps and gauze which were next to a towel on the floor. R1 had a flyswatter in his room and killed one live fly and two others were observed in the room and landed on the dressings piled directly on the floor. There was a prominent foul odor in his room. On 06/24/24 at 07:57 AM, R1 stated while at the wound clinic, two maggots were found under his dressing. R1 was not able to recall for sure the exact date. On 06/24/24 at 10:34 AM, Licensed Nurse (LN) G stated she was going to take the rest of the wraps off of R1's legs and clean them and did not have an order yet for any dressings. R1 was sitting in his recliner in his room. There was a live fly observed in R1's room during the process of a dressing change performed by LN G. On 06/24/24 at 12:36 PM, Housekeeping Staff U stated the only issues with flies she had seen in the facility was in R1's room, which she thought was due to his legs that leaked fluids which smelled like rotten eggs. Housekeeping Staff U stated when she was in there yesterday his bandages were soaked through. When asked what was done about the flies in R1's room Housekeeping Staff U stated, I don't have a fly swatter and she had not killed any in his room. On 06/24/24 at 12:46 PM, LN G stated she had not seen any maggots on R1's skin or dressings but received in report one day they were found at the center where his wraps were done. On 06/24/24 at 12:54 PM, LN H stated she heard R1 had maggots in his leg dressings from R1 and LN J on one of the days he went to the clinic for wound treatment. On 06/24/24 at 01:06 PM, LN J stated R1 told her that last week when returning from the clinic they (clinic staff) found maggots. She verified there have been flies in his room, and thought he had a fly swatter in his room. LN J stated she had not killed any flies in his room and seemed like that was the only room that had them. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/24/21 at 01:11 PM, Administrative Nurse E stated R1 returned from the center where his wraps are done and reported maggots were found, so she called the center to clarify what he had said. Administrative Nurse E stated she was told by Consultant Staff GG on 06/17/24 of two maggots found and had not seen any on 06/14/24. On 06/24/24 at 02:37 PM, Consultant Staff GG stated she had been doing the lymphedema wraps and when R1 came in on 06/17/24 his wraps were soiled with urine and his legs weep a lot. The dressings in place were dated 06/13/24 and were the ones she had placed on that day when she evaluated him. When she was unwrapping R1's right leg on 06/17/24, she observed a maggot toward the top of his leg and one on his ankle. Consultant GG stated she did not call the facility right away regarding the maggots as she had another patient and Administrative Nurse E had called her and she gave Administrative Nurse E instructions on keeping the wraps on and clean unless they became soiled. On 04/24/24 at 04:30 PM, Maintenance Staff V stated he was not aware of any concerns about flies in the facility, a pest control company came out monthly, usually the first week of the month and had not been informed of any fly issues. Maintenance Staff V stated he was not aware of any residents having maggots found on their skin. Maintenance Staff V stated the staff will verbally tell him about any problems or put the concern in the TELS system (electronic communication system). Maintenance Staff V stated if he had been made aware, he could have had the pest control company come out to address. On 06/24/24 at 04:56 PM, Administrative Staff A stated, when asked what the facility had done to address the issue of maggots being found on R1's skin, he stated he was not aware of maggots being found until today (06/24/24) from one of the nurses after the surveyor's arrival on site. The facility policy Pest Control dated 09/01/14 revealed it was the policy of the center to maintain an effective pest control program. The facility maintains an on-going pest control program to ensure that the building was kept free of insects and rodents. Maintenance services assist, when appropriate and necessary, in providing pest control services. The facility failed to ensure they maintained an effective pest control program resulting in R1 having maggots identified on his skin when Consultant Staff GG removed a dressing from his right leg at an appointment and observation of flies in R1's room.