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	03/05/2026

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** The facility identified a census of 57 residents. The sample included three residents. Based on observation, interview, and record review, the facility failed to ensure Resident (R) 1 received the necessary care, including his personalized physician ordered medication regimen, to alleviate terminal agitation and promote comfort as intended by the hospice provider resulting in increased anxiety/agitation, a fall with an injury and low back pain. Findings included:- R1's Electronic Medical Record (EMR) documented a diagnosis of unspecified visual loss, muscle weakness, 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), altered mental status (a non-specific, change in brain function, resulting in confusion, decreased alertness, or behavioral changes), and unspecified vision loss. R1's admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. The MDS documented R1 had lower extremity impairment on one side and had a limb prosthesis. He used a walker and a wheelchair. The MDS documented R1 was dependent on staff for toileting hygiene and required substantial to maximal assistance for bathing, lower body dressing, putting on or taking off footwear, and wheelchair mobility. R1 required partial or moderate assistance for shower or tub transfers, and transitioning between lying to sitting, and sitting to standing. The Functional Abilities Care Area Assessment (CAA), dated 02/10/26, documented the CAA triggered secondary to assistance required in activities of daily living (ADL), impaired balance, and functional impairment in activity. The CAA further documented contributing factors, including generalized weaknesses and decreased safety awareness. The CAA documented risk factors included further ADL decline, falls, incontinence, skin breakdown, and pain. The Psychotropic Drug Use CAA dated 02/10/26, documented the CAA triggered secondary to the use of psychotropic medications to manage a psychiatric illness or condition. The CAA documented contributing factors included current history of depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), psychosis (any major mental disorder characterized by a gross impairment of perception), and insomnia (inability to sleep). The CAA documented risk factors included increased falls, impaired balance, and potential for adverse effects of medication. The Psychosocial CAA dated 02/10/26, documented the CAA triggered secondary to feelings of sadness, lack of interest, and feeling bad about oneself. The CAA documented R1 stated he had little interest in normal favorite activities and stated he wished he were dead. The CAA documented contributing factors included diagnoses of depression, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), new placement in a facility, and living in a facility for an extended time. The CAA documented risk factors included decreased socialization, worsening depression, and anxiety. R1's 03/02/26 Care Plan documented R1was on hospice care related to end-of-life care for a terminal diagnosis of cerebral infarction. The plan included the following interventions dated 03/02/26:Staff were to coordinate the care plan with hospice.Staff were to notify hospice of any change in condition or medication changes.Staff were to provide emotional support to the patient and family during the dying process. R1's 03/02/26 Care Plan documented R1 had potential for drug-related complications associated with the use of psychotropic (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 0684 Level of Harm - Actual harm Residents Affected - Few	medications related to anti-anxiety medication. The plan included the following interventions dated 03/02/26:Staff were to provide medications as ordered by the physician and evaluate for effectiveness.Staff were to observe for side effects and report to the physician.Staff were to provide non-pharmaceutical interventions of offering fidget items to decrease target behaviors, anxiety, or depression.A psychotropic medication risk and benefit and reduction plan as recommended by the physician and pharmacist. A Durable Power of Attorney (DPOA) for Healthcare Decisions dated 10/21/21, documented Administrative Nurse E was R1's primary DPOA, and R1's Representative was recorded as R1's alternate DPOA. The document recorded R1's DPOAs were authorized to consent, refuse, or withdraw consent to any care, procedure, treatment, or service to diagnose, treat, or maintain a physical or mental condition, including artificial nutrition and hydration. R1's EMR recorded the following orders:Clonazepam (anti-anxiety medication) 0.5 milligrams (mg) two times a day for anxiety related to altered mental status, started 02/06/26 and discontinued on 02/24/26. Seroquel (antipsychotic - class of medications used to treat major mental conditions which cause a break from reality) 50 mg one time a day for dementia with distressing psychotic features that diminish quality of life and pose a risk to others, started 02/09/26. A Provider's Order dated 02/20/26, and signed by Consultant GG, documented the following orders:Ativan (anti-anxiety medication) 0.5 mg three times a day for 14 days for agitation and irritability.Admit to hospice. A General Notes dated 02/24/26 recorded R1 admitted to hospice services. All medications were discontinued except Tylenol 500 mg two tabs three times daily, clonazepam 0.5 mg twice daily, Lantus (long-acting insulin) 14 units daily, lorazepam 0.5 mg three times daily, Tramadol 50 mg every six hours as needed, and Seroquel 50 mg twice daily. A hospice Progress Report dated 02/24/26 documented an admit visit between hospice and R1's DPOA (Administrative Nurse E). A text message, reviewed and verified from Administrative Nurse D to Administrative Nurse E sent on 02/25/26 at 12:30 PM, documented Administrative Nurse D asked Administrative Nurse E why R1 had both scheduled Ativan and clonazepam and texted the resident did not need both. Administrative Nurse E responded that the medications were ordered by R1's primary care provider (PCP), Consultant GG. Administrative Nurse D replied and stated R1 cannot be on both and texted that Consultant GG would have to pick one or the other. Administrative Nurse D responded and said she required Administrative Nurse E to call Consultant GG because R1 could not have both, there was no monitoring entered, and no consents. A Provider's Order dated 02/25/26, and signed by Consultant GG, documented the following orders:Continue lorazepam (Ativan) 0.5mg three times a day for dementia and altered mental status.Continue Seroquel 50 mg twice a day.Discontinue clonazepam. LN G documented a General Notes dated 02/25/26 at 02:53 PM, noting new orders to discontinue R1's clonazepam. A General Notes marked as a late entry had a created date of 02/25/26 at 02:55 PM and an effective date of 02/25/26 at 03:17 PM, documented R1 came to the nurse's desk and asked to talk to his daughter (Administrative Nurse E). The note documented R1 wheeled himself over to the other side and wanted to talk with his daughter, Administrative Nurse E. The note documented that Administrative Nurse E told the nurse that Administrative Nurse E told R1 that she was working and that she would talk to R1 when she was able. The note documented that staff brought R1 back to the west side of the facility; R1 was upset. The note documented R1 became upset when asked to take his medications and stated he would not take the medications and said he thought staff was trying to poison him. The note documented R1 picked up a folding table, went down to the south door, and watched the traffic. Staff approached R1 several times and asked him to take his medication. R1 became agitated and yelled that he was going to throw the table through the door. The nurse asked R1 if they could put the table where it belonged, and R1 gave the table back to the staff and was pleasant at that moment. The note documented that R1 continued to refuse medications, was very agitated, and threatened staff. The note documented that the staff called Administrative Nurse E and then reapproached R1 about taking his medications. The note documented R1 took the medications and went back to his room. A General Notes dated 02/25/26 at 07:45 PM documented R1 yelled for help. Staff entered R1's room, and R1 was on the side of the bed trying to (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	put on his prosthetic leg. R1 stated he needed to get some things out of the truck. The note further documented that R1 had knocked over the water pitcher, and snacks were also knocked to the floor. Staff assisted R1 back to bed and cleaned the area. A hospice Progress Report dated 02/26/26 documented R1 refused all care. A hospice Progress Report dated 02/27/26 documented the hospice nurse visited R1 in the facility. The resident was only alert to himself. The hospice nurse visited with LN G, who expressed no concerns. The hospice nurse then spoke with Administrative Nurse D, who informed the hospice nurse that R1 could not be on scheduled clonazepam and lorazepam and told the hospice nurse that she wanted R1's PCP notified that the orders needed to be changed. A General Notes dated 02/28/26 documented R1 was visibly upset, tearful, and filled with worries. The note documented R1 expressed that he was confused about where he was and that he was upset that he did not know where his daughter was. The note further documented R1 had delusions about the Air Force being in the facility to clean up. R1's face was filled with worry, and he had an expression that indicated he was fearful; he was grimacing. The note documented that staff administered R1 medication for lower back pain. A General Notes dated 03/01/26 documented R1 was standing up in his room, leaning against the refrigerator. The note documented R1 called out for help, and staff assisted him to his wheelchair and took him to lunch. R1 declined to eat lunch and instead drank two glasses of orange juice. R1 also declined snacks. A General Notes dated 03/01/26 at 04:39 PM documented R1 had an unwitnessed fall in the hallway; R1 reported to staff he was trying to go downstairs. R1 sustained a small skin tear to his right elbow and appeared to have discomfort, so staff administered pain medication. The note recorded staff were unable to complete a blood pressure measurement because R1 was unable to sit still. A hospice Progress Report dated 03/04/26 documented the hospice nurse visited R1. The nurse noted R1 had increased restlessness and agitation. A Physician's Progress Notes dated 03/04/26 documented a clarification medication order from the hospice provider. The document recorded orders for the following:Restart clonazepam 1 mg, three times a day for agitation related to altered mental status for 14 days.Discontinue the current scheduled lorazepam order and start lorazepam 0.5 mg every four hours as needed for anxiety or restlessness, or for 14 days. Review of R1's Medication Administration Record (MAR) for February 2026 and March 2026 revealed R1 received narcotic as-needed pain medication in addition to Tylenol six times (no more than once daily) over the 19-day period. between 02/04/26 and 02/247/26. After R1's clonazepam was discontinued on 02/24/26, R1 required as-needed narcotic pain medication daily until 03/03/26, when the as-needed pain medication was changed to Percocet 5 mg three times daily, scheduled. On 03/05/26 at 10:58 AM, R1 slept in a recliner in his room with no signs of distress observed. On 03/04/26 at 04:05 PM, LN G stated R1 was prescribed Ativan and clonazepam together initially. LN G stated she heard Administrative Nurse D tell Consultant HH that R1 could not be on both Ativan and clonazepam, and if R1's DPOA did not like that then she could take R1 home. LN G stated Administrative Nurse D said R1's DPOA would have to choose one or the other, as R1 could not be on both. LN G stated Administrative Nurse D made these comments at the desk in front of her and was speaking to Consultant HH at the time. LN G stated R1 had more agitation after the medication was discontinued. On 03/04/26 at 04:30 PM, Consultant HH stated R1 admitted to hospice services on 02/24/26, and upon his admission, they received signed orders from Consultant GG and all medications that were given in the facility. She stated this information was also placed in the hospice chart. Consultant HH stated on 02/27/26 a staff nurse told her the clonazepam had been stopped. She stated hospice never received an order from the PCP to stop that medication, and if that order was received at the facility, it was never communicated to hospice. Consultant HH stated she contacted the primary care doctor's office to ask about the discontinued medication, but was unable to reach anyone, so she left a message. Consultant HH stated she questioned facility staff and was told R1's clonazepam was no longer ordered, and he was no longer getting it. Consultant HH stated she had noticed some increased agitation and confusion from R1 after the medication was discontinued and said she was not certain that R1's increased behaviors and agitation were caused by discontinuing (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	the medication, but confirmed his behaviors, anxiety, and agitation had increased t around the time the medication was stopped. Consultant HH stated R1 had a fall on 03/01/26, which was communicated to hospice. Consultant HH stated Administrative Nurse D stated it was dumb to have R1 on clonazepam, Ativan, and Seroquel at the same time. Consultant HH stated that Administrative Nurse D told her that if R1's PCP did not want to give the orders to discontinue one of the antianxiety medications as she requested, she would go above the PCP's head to the facility's medical director and have the medication discontinued that way. Consultant HH stated Administrative Nurse D told her R1 could not be on clonazepam and Ativan at the same time. She stated Administrative Nurse D told her either the anti-anxiety medication R1 stayed on would need to be increased, or the Seroquel would need to be increased, but R1 could not be on both anti-anxiety medications at the same time. Consultant HH stated when she was in the facility on 03/02/26 R1 was very confused and was not having a great day. She stated the hospice doctor gave a new order to restart the clonazepam at one mg three times a day and changed the Ativan to an as-needed medication which helped R1 be less anxious and more comfortable. On 03/05/26 at 11:05 AM, R1's DPOA stated R1 was on both clonazepam and Ativan to try and get ahead of the behaviors that he typically had in the late afternoon going into the evening. She stated R1 was more restless, fidgeted more in the evenings, and was not sleeping well since the clonazepam was discontinued. R1's DPOA confirmed that Administrative Nurse D told her R1 could not be on both Ativan and clonazepam and said she would have to pick one or the other, so R1's DPOA spoke to R1's PCP about the medications. She told R1's PCP that she was exhausted from the ongoing battle with Administrative Nurse D over R1's medications. R1's DPOA stated she felt as though she had no choice but to have one of the medications changed due to the pressure from Administrative Nurse D even though it was not in R1's best interest. R1's DPOA stated she was concerned about retaliation from the facility if she did not have one of the medications discontinued and was fearful R1 would be forced to leave the facility and Administrative Nurse D had told her if she refused to comply, Administrative Nurse D would just get the facility's medical director to discontinue R1's medications. R1's DPOA said she felt harassed and bullied to get R1's PCP to discontinue the clonazepam. R1's DPOA stated R1 did not deserve to be treated that way and said R1 had spent his whole life doing things for everyone else, and he did not deserve to be miserable. R1's DPOA stated she was happy with the results from R1's medication regimen that included the lower dose of Seroquel, clonazepam, and Ativan, and said this is the regimen that best helped R1 be comfortable and less anxious. R1's DPOA said it was not in R1's best interest to have the medications changed as it had a negative impact. On 03/05/26, Administrative Nurse D was unavailable for interviews. On 03/05/26 at 12:53 PM, Administrative Staff A stated Administrative Nurse D did not have authority to dictate what medications residents were allowed to take. Administrative Staff A stated he believed it was in the best interest of the residents to receive the medications the provider deemed appropriate to meet their needs. He said he felt there was room for conversation between the nurse and doctor regarding prescribed medications, but ultimately, the power resided with the prescribing authority. Administrative Staff A stated it would have been more appropriate for Administrative Nurse D to clarify if she had issues with the medication, instead of just saying R1 could not have the medication. On 03/05/26 at 05:05 PM, Consultant GG stated she was aware of the concurrent clonazepam and Ativan orders for R1. She stated R1 was on clonazepam prior to coming to the facility, and she changed it to twice a day and then later added the Ativan. Consultant GG stated she had planned on weaning R1 down over the course of a few weeks but stated she was unable to get to that point because she was told staff at the facility had an issue with R1 being on both clonazepam and Ativan. Consultant GG stated R1 was placed on hospice, and he could have been weaned down on clonazepam and changed to Ativan, and hospice usually uses that for residents receiving their services; however, she did not want to just stop the clonazepam abruptly, as there was worry of potential side effects. She stated she spoke to R1's DPOA about the medication situation and felt like someone at the facility was giving R1's DPOA a hard time about R1's (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	medications. She stated that ideally, she would have kept R1 on both (clonazepam and Ativan) for another one to two weeks, weaned him down every week, and slowly increased the Ativan. She stated she felt like someone at the facility put pressure on R1's DPOA to put pressure on her, as the provider, to discontinue one of the medications. On 03/09/26 at 12:27 PM, R1's representative stated he went to meet with Administrative Staff A and Administrative Nurse D to discuss concerns he had related to R1's increased agitation and anxiety, resulting in a fall and increased pain for R1. R1's representative expressed concern regarding R1's medications and being told by the facility that R1 could not have both the Ativan and clonazepam. The facility's Use of Psychotropic Medications policy, dated February 2026, documented that it is the intent of this policy to ensure that residents only receive psychotropic medications when other nonpharmacological interventions are clinically contraindicated. Additionally, these medications should only be used to treat the resident's medical symptoms and not used for discipline or staff convenience, which would deem it a chemical restraint. A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. Psychotropic drugs include, but are not limited to, the following categories: antipsychotics, antidepressants, anti-anxiety, and hypnotics. Psychotropic medications are to be used only when a practitioner determines that the medication is appropriate to treat a resident's specific, diagnosed, and documented condition and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication.