STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175239	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Diversicare of Council Grove	400 Sunset Drive Council Grove, KS 66846

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 52 residents. The sample included one resident reviewed for involuntary discharge. Based on observation, record review, and interview, the facility initiated a 30-day involuntary discharge for Resident (R)1 though R1's clinical record did not contain evidence to validate the reason for the involuntary discharge. This deficient practice placed R1 at risk for impaired health and well-being and involuntary discharge from the facility. Findings included: - R1's Electronic Health Record (EHR), under the Diagnosis tab, recorded diagnoses of schizoaffective disorder bipolar type (characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought) diabetes mellitus type two (DM2 - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), heart failure (chronic inability of the heart to pump blood sufficiently which results in shortness of breath), visual loss [to] both eyes, personality and behavioral disorders, alcohol abuse with alcohol-induced mood disorders, a need for assistance with personal cares, and difficulty in walking. R1's admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. The assessment documented R1 had verbal behavioral symptoms towards others four to six days and rejection of care one to three days, during the seven-day observation period. R1's Quarterly MDS dated 03/25/25 documented a BIMS score of 15. The assessment documented R1 had verbal behavioral symptoms towards others and other behavioral symptoms not directed towards others one to three days during the seven-day observation period. R1's Care Plan reviewed on 06/12/25 revealed no discharge planning care plan interventions before 02/07/25. R1's Care Plan documented on 07/08/24 R1 sometimes had behaviors that included cursing, shouting/yelling during care, and refusing care. The plan instructed staff to administer medications as ordered, assist the resident to avoid situations or people who were upsetting, offer diversions, report to the provider if behaviors interfered with daily living, ensure the resident was not in pain or discomfort, inform R1 what staff would do before beginning and speak to him in an unhurried manner and calm voice. (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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R1's EHR under the Progress Notes revealed the following notes: A note dated 01/03/25 at 09:28 PM, documented R1 would display a tantrum if R1's wishes were not immediately addressed. The note documented R1's behaviors included screaming expletives at staff, slamming his hand on a wall or table and kicking furniture; R1 attempted to bully staff to provide skin treatments and medications that were not ordered in the EHR. R1's EHR lacked evidence of interventions attempted to address the documented behaviors. A physician note dated 01/08/25 at 04:56 PM documented R1 had mixed complaints as well as argumentative and defiant behaviors. The physician documented R1 did not display good judgment or insight into reality. A note dated 01/12/25 at 05:08 PM documented R1 had good days and bad days and described that R1 accused staff and other residents of stealing his drinks and cigarettes. R1 displayed a tantrum at times when he didn't get his way and attempted to loudly bully staff when angry or if he had to wait. The note lacked evidence of interventions attempted to address the documented behaviors. A note dated 01/19/25 at 10:59 AM documented R1 was well-behaved for periods of time. R1 refused to accept he had smoked his cigarettes and accused others of stealing his cigarettes. The note lacked evidence of interventions attempted to address the documented behaviors. A note dated 01/21/25 at 05:55 AM documented R1 became angry when an (unnamed) Certified Nurse Aide (CNA) staff asked R1 to repeat himself because they could not hear R1's request. R1 swore at the staff and threw his shoe at staff. The note lacked evidence of interventions attempted to address the documented behaviors. A note dated 01/30/25 at 10:47 AM documented R1 was verbally abusive to staff and another resident. Staff documented behaviors that included R1 yelled at staff due to R1 not getting his breakfast fast enough. The entry lacked documentation of verbal statements made to any other residents and lacked evidence of interventions attempted to address the documented behaviors. A note dated 02/02/25 at 02:22 AM documented R1 yelled at staff and set off the door alarms; it took approximately three hours for staff to calm R1. A note dated 02/02/25 at 11:10 AM documented R1 accused R2 of being in his room, taking R1's cigarettes, and moving R1's bedding and furniture. The note recorded staff had not observed R2 in R1's room. R1 accused R2 of walking around with his genitals exposed and stated he did not want to be around R2. Staff documented calling Administrative Nurse D who advised staff to move R2 to a different room. A note dated 02/02/25 at 01:52 AM documented staff assisted R1 to the dining area where he began yelling and asked where the man who walked around with his genitals exposed was. Staff asked R1 to leave the dining area due to disruptive behaviors. R1 refused and rolled his wheelchair into staff and began swearing at staff. A note dated 02/02/25 at 03:41 PM documented R1 called staff expletive names. Staff described R1 as belligerent though the note evidence of interventions attempted to address the documented behaviors. (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A note dated 02/07/25 at 09:39 AM documented R1 sat in his wheelchair near the nurse's station and when staff approached, R1 rolled his wheelchair forward and struck a staff member on the legs with his wheelchair. R1 laughed and reported to the staff that he could not see her then requested a urinal so he could urinate in the common area. Staff assisted R1 to his room and handed him his urinal. Staff documented R1 then yelled and stated he did not want to use the urinal in his room. R1's EHR lacked documentation from a physician that R1's needs could not be met at the facility, or that R1 had placed other residents in danger warranting involuntary discharge. The facility was unable to provide evidence of investigative reports or incident reports regarding the alleged inappropriate behaviors of R1 towards other residents or behavioral interventions that were attempted but were unsuccessful. A review of documents provided by Administrative Staff A revealed a letter sent by Administrative Staff A to R1 on 02/07/25 which stated RE: Notice of Transfer or Discharge that documented R1 would be discharged from the facility on 03/10/25 because the transfer or discharge is necessary because the health of other individuals may be at risk if R1 remained in the facility. A review of documents provided by the Long-Term Care Ombudsman (LTCO) revealed a letter that formally requested to withdraw the involuntary discharge letter to R1 due to a change in circumstances, postmarked 04/12/25. During an observation on 06/12/25 at 11:40 AM, R1 rested in bed with his eyes closed. During an interview on 06/12/25 at 01:05 PM, Administrative Staff A reported R1 was scheduled to be discharged to home under the care of his daughter, and the family was involved with the planning process. Administrative Staff A reported that for an unknown reason, R1's family was not agreeable to his discharge home under the care of his representative. Administrative Staff A said R1's representative refused to acknowledge R1's behavior which included sexual aggression and violence towards staff. Administrative Staff A stated R1 had bragged about being evicted from multiple other facilities for behaviors that included fondling another resident at a different facility. During an interview on 06/12/25 at 02:05 PM, Administrative Nurse D revealed R1 refused care approximately 70 percent (%) of the time and then accused staff of neglect. Administrative Nurse D said R1 frequently instigated confrontations with staff to elicit a negative response and/or to get his demands met and R1 chose to be discharged from the facility to live with his representative. Administrative Nurse D reported that the facility had no reportable incidents, including no resident-to-resident altercations involving R1, during the survey review period of 01/01/25 to 06/12/25. During an interview on 06/12/25 at 04:10 PM, Certified Medication Aide (CMA) R reported R1 had his good days and bad days and denied any known physical or verbal aggression towards other residents. CMA verified all of R1's behaviors were directed at staff. During an interview on 06/12/25 at 04:15 PM, CNA M revealed R1 had yelling behaviors toward staff, but she denied knowledge of any physical behaviors R1 had towards other residents or staff. (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/12/25 at 04:18 PM, Administrative Nurse E reported that R1 would moan and grumble whenever he had to wait for staff assistance. Administrative Nurse E denied R1 had any physical altercations with other residents and stated that there were multiple occasions in which R1 was verbally inappropriate and aggressive towards other residents. Administrative Nurse E went on to say R1 was irritable, impatient, and had threatened other residents. Administrative Nurse E reported when staff assisted other residents around R1, they attempted to be greater than an arm's length away. During an interview on 06/12/25 at 04:37 PM, Administrative Staff A stated on 02/02/25 during the verbal exchange between R1 and R2, R1 threatened to kill R2. Administrative Staff A confirmed that no reportable incident report existed because she did not recognize it as resident-to-resident abuse and therefore did not report the incident to the State Agency (SA). The facility did not provide a policy related to involuntary discharge.