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	07/08/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. The facility reported a census of 46 residents. The sample included three residents. Based on observation, interview, and record review, the facility failed to treat residents in a dignified manner when Resident (R)2 received personal care without privacy. This deficient practice placed the resident at risk for decreased psychosocial well-being and embarrassment.Findings included:- R2's Electronic Medical Record (EMR) revealed a diagnosis of a local infection of the skin and unspecified adult personality disorder.R2's 06/30/25 Significant Change Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition.Observation on 07/08/25 at 12:00 PM, Licensed Nurse (LN) G entered R2's room without shutting the door. LN G did not close the curtain to provide privacy. LN G proceeded to perform a dressing change on both of the resident's legs with the door and privacy curtain open, leaving the resident visible from the hall.On 07/08/25 at 12:25 PM, LN G confirmed she should have provided privacy for R2 when she provided his dressing change.On 07/08/25 at 02:10 PM, Administrative Nurse D confirmed she expected staff to treat all residents with respect and dignity by providing privacy with care.The facility's Clean Dressing Change Care Audit documented that staff were to inform the resident what the nurse was going to do and provide privacy by shutting the door and pulling the privacy curtain.

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility reported a census of 46 residents. Based on observation, interview, and record review, the facility failed to maintain a clean, comfortable, and homelike environment in the common living area for the residents of the facility. This placed the affected residents at risk for decreased quality of life.Findings included:- Observation on 07/08/25 at 10:38 AM revealed a strong odor of urine upon entering the facility from the east doors to the A-Hall unit.Observation on 07/08/25 at 10:42 AM, R3 sat in a reclining chair in the common area. R3's pants were wet on the front between the legs, and the seat of the chair was saturated. There was a strong odor of urine.Observation on 07/08/25 at 10:54 AM, Certified Nurse Aide (CNA) M and CNA N brought a sit-to-stand lift to assist R3 out of the recliner. As they lifted R3, they could see that the recliner and R3 were saturated. CNA M did not clean the chair, but requested that someone call housekeeping to clean the chair. On 07/08/25 at 11:16 AM, the recliner remained uncleaned. CNA M again requested that a staff member call housekeeping. Observation on 07/08/25 at 11:21 AM, Housekeeping Staff U brought a shampooer into the living area. She shampooed the seat of the recliner.Observation on 07/08/25 at 04:26 PM, the recliner remained wet with a wet floor sign in it. The recliner had multiple stains on the armrest, seat, footrest, and back of the chair where the head rests.On 07/08/25 at 12:15 PM, R3's representative reported that the smell in the facility was very bad. She remarked that the smell was worse on her family member's wing. On 07/08/25 at 12:52 PM, R3's husband said the facility was dirtier over the last six to eight months, and the smell of urine had gotten worse. On 07/08/25 at 2:40 PM, CNA O stated she did notice the strong urine smell. CNA O said that at times, staff used Bye-Bye Odor spray for the strong urine smell.On 07/08/25 at 04:56 PM, Administrative Staff A reported that she talked to the regional managers of the contracted housekeeping employees who will provide training and instruction for better cleaning and removal of unpleasant odors. The facility did not provide a policy related to creating and maintaining a clean, safe, and comfortable home-like environment for the residents of the facility.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	The facility reported a census of 47 residents, with two residents reviewed for wounds. Based on observation, interview, and record review, the facility failed to provide adequate wound care for Resident (R)1 to prevent the wound from being contaminated with maggots (fly larvae). This deficient practice led to R1's right lower leg wound becoming contaminated with maggots, which caused physical and psychosocial discomfort.Findings included:- R1's Electronic Health Record (EHR) documented diagnoses that included diabetes mellitus type 2 (DM2 - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), chronic veinous hypertension (high blood pressure in the legs) with inflammation of an unspecified lower extremity, edema (swelling resulting from an excessive accumulation of fluid in the body tissues), an open right lower leg wound, and need for assistance with personal care.R1's 03/26/25 admission Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The assessment documented R1 required substantial/maximal assistance with application of footwear and lower body dressing, and partial/moderate assistance for shower/bathing. The assessment documented no venous or arterial ulcers or lesions; R1 had surgical wound(s) that received surgical wound care and received application of non-surgical dressings and ointments/medications to areas other than the feet.The 03/26/25 Care Area Assessments (CAA) did not address R1's right lower leg wound.The 06/23/25 Quarterly MDS documented a BIMS score of 15. The assessment documented R1 required substantial/maximal assistance with application of footwear, partial/moderate assistance with lower body dressing, and supervision/touching assistance with shower/bathing. The assessment documented R1 had no venous or arterial ulcers/lesions or surgical wounds. R1 received surgical wound care and application of ointments and medications to areas other than the feet.R1's 03/17/25 Care Plan reviewed on 07/08/25 documented R1 had an old surgical wound, non-healing wound(s) to lower extremities with a risk for development of further wound(s) due to long-term open wound management and chronic edema. The care plan documented R1's wound would be free of signs and symptoms of infection and included the following interventions:Staff would administer medications and obtain labs as ordered, dated 04/03/25.Staff would wrap both legs with Unna boots (a compressive dressing to aid in circulation and wound healing) every three days, dated 04/03/25.The Orders tab of the EHR documented the following orders:Cleanse legs with Hibiclens (a topical antiseptic) daily and apply a clean dressing everyday shift, dated 06/25/25 at 06:00 AM.Mupirocin (a topical antibiotic) ointment 2 percent (%), apply to both legs topically twice per day, related to skin graft infection, venous hypertension, and open wound right lower leg, dated 04/26/25 at 07:00 AM.Apply calcium alginate (highly absorbent dressing) with antibacterial silver to wounds on both lower extremities. Cover with Hydralock (highly absorbent dressing with waterproof backing), then wrap with Kerlix (stretchy gauze bandage) and secure. Change every three days related to an open wound on the right lower leg, dated 05/24/25 at 07:00 AM.Eucerin (skin lotion), apply to both lower legs, topically, two times per day. Apply after Bactroban (a topical antibiotic), then apply absorbent dressing, wrap with Kerlix, and then Coban (self-adherent elastic wrap used to provide compression and secure dressings), dated 04/28/25 at 03:00 PM.The Progress Notes documented the following:On 06/23/25 at 10:24 AM, R1 received a shower at 09:40 AM. Her dressings were removed from both lower legs, and maggots were observed crawling on the skin of both ankles and heels. Staff left a message with R1's primary care physician (PCP) and were awaiting a call back.On 06/23/25 at 03:11 PM, R1's PCP returned the call and gave a telephone order to cleanse R1's legs daily with Hibiclens and apply clean dressings. R1's PCP requested a report back on 06/27/25 and further stated the maggots were probably good for the wounds.R1's June 2025 Medication Administration Record (MAR) and Treatment Administration Record (TAR) documented Administrative Nurse D updated R1's PCP about the wound on 06/27/25 at 12:38 PM.During an observation on 07/09/25 at 10:05 AM, R1 sat in her wheelchair with loose dressings on both lower legs. Both dressings appeared saturated with an unknown yellow liquid. Multiple flies were observed in R1's room and around R1. R1 was able to put her hands between the dressings and her legs.During an observation on 07/09/25 at 01:30 PM, Licensed Nurse (LN) G performed a dressing change on R1's lower extremity wounds. LN G noted both dressings appeared saturated and were falling off R1's legs. During the dressing change, both the surveyor and LN G observed maggots on R1's right lower extremity wound. LN G removed maggots from the wound while performing wound care.On 07/08/25 at 10:05 AM, R1 acknowledged she did have maggots in both lower extremity wounds and said she sometimes

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. The facility reported a census of 46 residents. Based on observation, interview, and record review, the facility failed to maintain an effective infection control program related to inadequate hand hygiene during wound care and inadequate cleaning of furniture. This deficient practice had the potential to spread possible infections to the residents in the facility.Findings included:- Resident (R)3's Electronic Medical Record (EMR) revealed diagnoses of cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness) due to 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), and a history of urinary tract infections (UTI-an infection in any part of the urinary system). R3's 04/27/25 Significant Change Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of two, indicating severe cognitive impairment. R3 was always incontinent of urine and bowel, and she required substantial to maximum assistance with toileting. R3's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) documented R3 required increased assistance with all areas of daily living. R3's EMR under Tasks documented R3 was continent one time in the last 30 days. R3's Care Plan dated 09/13/23 documented R3 was incontinent of bladder related to confusion, impaired mobility, and a history of UTIs. An intervention dated 09/17/24 directed staff to offer toileting assistance before and after meals, bedtime, and as needed at night. Observation on 07/08/25 at 10:42 AM, R3 sat in a reclining chair in the common area. R3's pants were showing wetness on the front of her pants between the legs, and the seat of the chair was saturated. There was a strong odor of urine. Observation on 07/08/25 at 10:54 AM, Certified Nurse Aide (CNA) M and CNA N brought a sit-to-stand lift. They told R3 that they were taking her to the bathroom, then to lunch. CNA M and CNA N attached R3 properly to the lift and lifted her to a standing position. As they lifted R3, they could see that she was wet from her knees to her mid-back above her waist. CNA M and CNA N assisted R3 from the fabric-covered recliner to the wheelchair and took her to the shower room to change and toilet her. CNA M did not clean the chair but requested that someone call housekeeping to clean the chair. CNA M and CNA N cleaned and changed R3's clothing. On 07/08/25 at 11:16 AM, the recliner remained uncleaned. CNA M again requested that a staff member call housekeeping. Observation on 07/08/25 at 11:21 AM, Housekeeping Staff U brought a shampooer into the living area. She shampooed the seat of the recliner. Observation on 07/08/25 at 04:26 PM, the recliner remained wet with a wet floor sign in it. The recliner had multiple stains on the armrest, seat, footrest, and back of the chair where the head rests. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/08/25 at 11:25 AM, Housekeeping Staff U said the housekeeping staff use hot water to clean urine off the chairs, and that is all that was in the shampooer. Housekeeper Staff U said the housekeeping staff did not use any chemicals for cleaning the chair. On 07/08/25 at 11:46 AM, Consultant GG stated nursing staff cleaned up bodily fluids like urine, and then housekeeping disinfected the surface. Consultant GG stated that each building had its own cleaning supplies, so which chemicals were used was dependent on what products the facility had. Consultant GG acknowledged that hot water alone was not a disinfectant. On 07/08/25 at 12:59 PM, Administrative Nurse D stated that if the soiled chair was cloth, it must be discarded, and if it was not cloth, nursing staff should immediately wipe the chair with a germicide wipe, then get housekeeping to clean the chair. Administrative Nurse D stated she expected chairs to be disinfected with a disinfectant, not just hot water. On 07/08/25 at 04:20 PM, Administrative Nurse D said 24 out of the 47 residents could transfer to the recliners with or without assistance and had the potential to be affected by this deficient practice. On 07/08/25 at 04:56 PM, Administrative Staff A reported that she talked to the regional managers of the contracted housekeeping employees who will provide training and instruction. The facility's Infection Control policy dated 11/01/17, documented that the center's infection control policies and practices are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections. - Observation on 07/08/25 at 12:00 PM, Licensed Nurse (LN) G entered Resident (R)2's room and donned gloves and gown without performing hand hygiene. LN G removed the wound dressing from R2's left leg. LN G cleansed the wound with water, Hibiclens wash (an antibacterial and antimicrobial skin cleanser), and gauze. Without washing her hands or changing gloves, LN G applied a clean Telfa (nonstick gauze) and Kerlix (stretchy gauze bandage) to the wound on R2's left leg. LN G changed her gloves but did not perform hand hygiene. LN G removed the dressing from the right leg and cleansed the wound with water, Hibiclens, and gauze. LN G changed her gloves without performing hand hygiene. LN G then applied a clean Telfa and Kerlix to the wound on the right leg. LN G doffed her gown, then her gloves. On 07/08/25 at 12:25 PM, LN G confirmed she should have washed her hands when entering the room. She should have performed hand hygiene and changed gloves after cleaning the wound and before applying clean gloves. LN G stated the correct order in doffing is gloves, then gown. On 07/08/25 at 02:10 PM, Administrative Nurse D confirmed she expected hand hygiene to be completed when a staff member goes into a room and out of a room, and when applying and reapplying gloves. Administrative Nurse D said staff should perform hand hygiene after touching a dirty area, prior to touching a clean dressing. Administrative Nurse D stated that when doffing gown and gloves, the gloves were to be removed first, hand hygiene performed, then remove the gown with hand hygiene again. The facility's Infection Control policy, dated 11/01/17, documented that the center's infection control policies and practices are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. The facility had a census of 46 residents. Based on observation, interview, and record review, the facility failed to ensure effective pest control in the facility. This deficient practice placed the affected residents of the facility at risk for decreased health and wellness. (Refer to F684) Findings included: - On 07/08/25 at 08:05 AM, 10:20 AM, and 12:00 PM, observation of R2's room revealed a lot of flies in the room. Further observation revealed a fly paper strip hanging from the ceiling in R2's room next to the closet. On 07/08/25 at 10:05 AM, 01:30 PM, and 03:05 PM, observation of R1's room revealed a lot of flies in R1's room. R1's room did not show any evidence of any fly mitigation attempts. On 07/08/25 at 01:30 PM, observation of wound care on R1's right lower leg revealed live maggots (fly larvae) on R1's right lower leg wound.On 07/08/25 at 02:10 PM, Administrative Nurse D revealed that the facility had been concerned about flies for a while, and Administrative Staff A had been implementing fly mitigation strategies. On 07/08/25 at 05:00 PM, Administrative Staff A revealed the facility had identified R1's room, R2's room, and some other unidentified residents' rooms as problem areas related to flies. The facility had installed fly paper strips, but this was ineffective. The facility had ordered fly bags (a liquid-filled bag with a one-way valve used to trap and eliminate flies), and they had arrived but had not been installed. Administrative Staff A revealed that the cause of the flies was due to the mostly rural area and the prevalence of cattle in the area. The facility did not provide a policy related to pest management.