STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Diversicare of Council Grove	400 Sunset Drive Council Grove, KS 66846

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on interviews, observation, and record review, the facility failed to utilize Enhanced Barrier Precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms which employ targeted gown and glove use during high-contact care) while providing direct care to a Resident (R) 5 with open wounds to her left heel and left gluteal (buttock) fold. Additionally, the facility failed to ensure adequate hand hygiene during a wound measurement for R1. The facility failed to properly transport clean linen and personal linens in a sanitary manner to prevent cross contamination.Findings included:1. On 07/06/2026 at 09:45 AM, Certified Nurse Aide (CNA) M was observed to have several uncovered washcloths and towels held up against her uniform that she carried in the 100 hallways.On 07/07/2026 at 08:58 AM, CNA M reported that she should have covered the pile of washcloths and towels she carried down the hallways and not have them up against her uniform. 2. On 07/06/2026 at 12:00 PM, Laundry Staff W delivered personal linens with a covered cart. As Laundry Staff W removed the personal clothes from the cart, she held the clothes up against her uniform as she entered several of the residents' rooms in A unit hallway. Laundry Staff W performed no hand hygiene in between residents' rooms as she opened closets and removed hangers.On 07/06/2026 at 12:09 PM, Laundry Staff W reported she was told by her supervisor she did not need to wash her hands in between rooms, as she is only touching the closet handle, and she reported that she did realize she held the clothes and blankets against her uniform, as sometimes it was a heavy load to grab. On 07/08/2026 at 09:31 AM, Housekeeping Supervisor V expected the staff to wash hands between residents' rooms as the staff needed to open drawers and closets. She also expected the staff to never hold the linen or personal clothes up against their uniforms. 3. On 07/07/2026 at 02:12 PM, CNA M and CNA P transferred R5 with a mechanical lift. CNA M and CNA P did not have a gown on and only used gloves. R5 had an EBP sign on her door with personal protective equipment (PPE- gowns, face shields and/or eyeglasses/goggles, and gloves) hung on the door. R5 has an open area on her left heel and her left gluteal fold. CNA M and CNA P provided peri care to R5 while only wearing gloves for the care provided. The CNAs confirmed they did not wear a gown as part of required PPE on inquiry.On 07/08/2026 at 07:44 AM, Administrative Nurse D and Administrative Nurse E were in R1's room taking photographs of her wounds. Neither of the nurses had their PPE gowns tied, and their gowns kept falling off their shoulders while completing the wound measurements when assisting R1 to reposition in bed and when the disc marker (to help align the image for accurate measurement and documentation) was applied near each open wound for the photograph. Administrative Nurse E took a picture of R1's right buttock open wound, removed the disc marker sticker, and then removed one glove from her right hand and kept the other glove on her left hand. No hand hygiene was performed; she then applied a clean glove on her right hand. Administrative Nurse E took a photo of the left buttock wound, removed the disc marker, removed her right glove, no hand hygiene was performed, and applied a new glove to her right hand. Observed several open areas on buttocks, sacrum, and back of thighs; small amount of serosanguineous (semi-thick blood-tinged drainage) drainage noted on the brief.On 07/08/26 at 12:45 PM, Administrative Nurse D reported she expected the staff to wear the PPE correctly and reported that the tie on her gown had broken and she should have changed the gown. Administrative Nurse E (continued on next page)

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	reported it depended on what the staff was doing to make it acceptable to only remove one glove and apply another glove. Administrative Nurse E reported she did not want to contaminate her camera. Administrative Nurse D reported she expected the staff to remove both gloves and perform hand hygiene before new gloves were applied. Administrative Nurse D expected the staff to wear gowns when residents were on EBP when completing hands-on care. Administrative Nurse D reported she expected the laundry to not be touching the uniforms, to be covered, and expected the staff to wash hands in between rooms when passing linen.The facility's policy Infection Control Guide, dated 2025, documented enhanced barrier precautions refers to the expanded use of PPE and refers to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of multiple drug-resistant organisms (MDROs- common bacteria that have developed resistance to multiple types of antibiotics) to staff hands and clothing. MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. Hand Hygiene before and after patient/resident contact, including after gloves are removed. Handling of clean linen was not addressed in infection control.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on interview and record review the facility failed to designate a qualified Infection Preventionist (IP), who had completed specialized training in infection prevention and control, to be responsible for the facility's Infection Prevention and Control Program (IPCP).Findings included:- On 07/08/2026 at 12:45 PM, Administrative Nurse E (Interim) revealed she could not locate her IP certificate. She reported that when she accepted the interim position, an IP certification was not mentioned, and she reported that she really had not completed much of the IP duties at the facility. Administrative Nurse E reported that she was enrolled at this time and taking courses for IP.On 07/08/2026 at 12:50 PM, Administrative Nurse E produced the antibiotic/infection control log binder. There was a Completion for Nursing Home Infection Preventionist Training Course dated 07/07/2026 for Administrative Staff A. On 07/08/26 at 01:00 PM, Administrative Staff A reported that she thought Administrative Nurse E had a current IP certificate and expected the facility to have a designated certified IP employed at the facility. The facility did not provide a policy for an Infection Preventionist.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Five Certified Nurse Aide (CNA) staff who worked in the facility for more than 12 months were reviewed for the required in-service training. Based on interview and record review, the facility failed to develop, implement, and permanently maintain an in-service training program for CNA staff with the required topics and no less than 12 hours per year. Findings included:- Review of CNA personnel files revealed the following:CNA N, hired on 04/04/2007, lacked the total hours calculated for the 12 hours required.Certified Medication Aide (CMA) T, hired on 12/20/2012, lacked the total hours calculated for the 12 hours required. Additionally, CMA T lacked the required education on abuse, neglect, exploitation, and dementia education. CNA MM, hired on 03/25/2023, lacked the total hours calculated for the 12 hours required. Additionally, CNA MM lacked the required dementia training. CNA M, hired on 03/07/2024, lacked the required dementia training.CNA O, hired on 02/12/2025, lacked the total hours calculated for the 12 hours required. Additionally, CNA O lacked the required dementia training.On 07/08/2026 at 10:00 AM, Administrative Staff A reported that she expected the CNAs to have the required 12 hours and the required training completed. The facility did not provide a policy for staff training.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to complete the Care Area Assessment (CAA- analysis of findings), related to a Comprehensive Minimum Data Set (MDS), for seven Residents (R)2, R3, R4, R7, R25, R48, and R52, to address the underlying cause, risk factors, and other contributing factors to ensure the resident received care based on their individual needs.Findings included:- Review of resident's most recent Comprehensive Minimum Data Set (MDS) documentation revealed the triggered Care Area Assessment (CAA) lacked completion as follows:1. R2's Annual MDS, dated 02/18/2026, lacked completion of CAAs dated 02/18/2026 for Communication, Functional Abilities (Self-Care and Mobility), Psychosocial Well-Being, Behavioral Symptoms, Activities, Falls, Nutritional Status, Dehydration/fluid Maintenance, Pressure Ulcer/Injury, and Psychotropic Drug Use.2. R3's admission MDS, dated 02/12/2026, lacked completion of CAAs dated 03/03/2026 for Pain, Cognitive Loss/Delirium, Functional Abilities (Self-Care and Mobility), Behavioral, Urinary Incontinence/Indwelling Catheter, Activities, Dehydration, Psychosocial well-being, Falls Communication, NS, Pressure Ulcer/Injury well-being'3. R4's Annual MDS, dated 03/05/2026, lacked completion of CAAs dated 03/19/2026 for Functional Abilities (Self-Care and Mobility), Cognitive Loss/Delirium, Urinary Incontinence/Indwelling Catheter, Activities, Psychosocial well-being, Dental, Pain, Communication, Nutritional Status, and Psychosocial well-being.4. R7's admission MDS, dated [DATE], lacked completion of CAAs dated 12/09/2025 for Functional Abilities (Self-Care and Mobility), Urinary Incontinence/indwelling Catheter, Falls, Nutritional Status, Dehydration/Fluid Maintenance, Pressure Ulcer/Injury, and Psychotropic Drug use.5. R25's Significant Change in Status MDS, dated 11/28/2025, lacked completion of CAAs dated 12/05/2025 for Cognitive Loss/Dementia, Urinary Incontinence, Psychosocial Well-being, Falls, Pressure Ulcer/Injury, and Communication.6. R48's Annual MDS dated 10/15/2025 lacked completion of CAAs dated 10/27/2025 for Functional Abilities (Self-Care and Mobility), Urinary Incontinence, Visual Function, Falls, Psychotropic Drug Use, and Nutritional Status. 7. R49's Annual MDS, dated 09/17/2025, lacked completed CAAs dated 09/25/2025, for Cognitive Loss/Dementia, Communication, Functional Abilities (Self-Care and Mobility), Urinary Incontinence and Indwelling Catheter, Nutritional Status, Falls, Dehydration/Fluid Maintenance, Pressure Ulcer/Injury, Dental Care, and Psychotropic Drug Use.8. R52's Annual MDS, dated [DATE], lacked completed CAAs dated 9/18/2025 for Functional Abilities (Self-Care and Mobility), Falls, Psychotropic Drug Use, Nutritional Status, and Pressure Ulcer/Injury.On 07/08/2026 at 08:30 AM, Administrative Nurse E stated she was not aware of a nurse at the facility who completed the MDS assessments and referred the inquiry to Administrative Nurse D.On 07/08/2026 at 08:45 AM, Administrative Nurse D reported she thought the MDS assessments were completed offsite and referred the inquiry to Consultant II.On 07/08/2026 at 08:59 AM, Consultant II confirmed the facility's MDS Comprehensive assessments were completed off-site by a Registered Nurse who was responsible for the accuracy and completion of the MDSs, including the comprehensive assessment with the analysis of findings/CAAs. She referred the inquiry to Consultant KK via telephone. Consultant KK reported the facility used the Resident Assessment Manual (RAI) October 2025 for guidance to complete the MDS and CAAs for comprehensive assessments. She confirmed the CAA completion should include the location of the information and resource materials that lead to the individualized analysis for the triggered areas of the CAA to develop the care plan. She verified the CAA documentation for the above-named residents lacked source documentation of information to indicate the analysis of the data collected, other than the narrative for the location of the data that triggered the CAA initially, and lacked analysis keeping with the guidance provided in the RAI Manual.The Resident Assessment Instrument (R.A.I.) Manual, titled The Care Area Assessment (CAA) Process and Care Plan Completion documentation, dated 2025, (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	included . Federal statute and regulations require nursing homes to conduct initial and periodic assessments for all their residents. The assessment information is used to develop, review, and revise the resident's care plans that will be used to provide services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The RAI process, which includes the Federally mandated MDS, is the basis for an accurate assessment of nursing home residents. The MDS information and the CAA process provide the foundation upon which the care plan is formulated. There are 20 problem-oriented CAAs, each of which includes MDS-based Trigger conditions that signal the need for additional assessment and review of the triggered care area. Detailed information regarding each care area and the CAA process, including definitions and triggers, appear in Chapter 4 of this manual. Chapter 4 also contains detailed information on care planning development utilizing the RAI and CAA process. CAA(s) completion is required for comprehensive assessments.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, interview and record review the facility failed to ensure a medication error rate of less than five percent when two errors were identified, resulting in a medication error rate of 7.41 percent. Finding included:- R22's Physician Orders recorded an order for acetaminophen (a medication to treat mild-to-moderate pain and fevers), tablet, 325 milligrams (mg), give 2 tablets by mouth three times a day related to chronic pain at 07:00 AM, 11:00 AM, and 05:00 PM, date ordered 04/16/24.R22's Physician Orders recorded an order for Refresh Tears ophthalmic solution (fast-acting, original-strength lubricating eye drops designed to soothe mild, occasionally dry eyes), instill 1 drop in both eyes three.times a day related to dry eye syndrome at 07:00 AM, 01:00 PM, and 08:00 PM, date ordered 03/09/25. On 07/07/2026 at 09:03 AM, Certified Medication Aide (CMA) R prepared R22's medications; she reported that she administered R22's 07:00 AM medications with all her other AM medications, as she has always done that. CMA R administered artificial tears, one drop in each eye, and administered the acetaminophen at this time; both medications were ordered for 07:00 AM. CMA R reported that she had not told a Licensed Nurse (LN) that she administered R22's medications late. On 07/07/2026 at 10:03 AM, CMA R reported that R22 had always used artificial tears and did not have Refresh eye drops; she reviewed the order in the EMR and reviewed the label on the artificial tears and reported that it was not the same ingredients as the Refresh eye drops. On 07/06/2026 at 10:15 AM, a medication substitution formulary was requested, and the facility did not provide one. On 07/07/2026 at 10:29 AM, Consultant Staff JJ (Pharmacist) reported that Refresh eye drops and the artificial tears R22 were administered and were not the same medication. Consultant Staff JJ reported that if a medication was scheduled at a specific time, the staff have an hour before or after to administer the medication. On 07/07/2026 at 01:39 PM, Consultant Staff II (Regional RN) reported she expected the medications to be passed one hour before or after a medication was scheduled. On 07/07/2026 at 06:00 PM, Consultant Staff II reported she believed the refresh eye drops were on back order and the artificial tears were on the substation formulary. Consultant Staff II was reminded that the formulary was requested and not received and that Consultant Staff JJ reported the eye drops were not the same medication. Consultant Staff II shook her head yes when she answered that if a different medication was being used, the physician order would be changed then. The facility's policy Medication Administration, dated 2026, documented that medications are administered by licensed nurses or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Ensure that rights of medication administration are followed: right drug and right time.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview and record review the facility failed to offer and provide or obtain an informed declination for the COVID-19 vaccine (a vaccine designed to prevent highly contagious respiratory virus) for Resident (R) 5, R44, R8, R48, and R49. Findings included:1. R5's Electronic Medical Record (EMR) lacked documentation of a COVID-19 vaccine being offered since 2021.2. R44's EMR lacked documentation of a COVID-19 vaccine being offered since 2024. 3. R8's EMR lacked documentation of a COVID-19 vaccine being offered since 2023.4. R48's EMR lacked documentation of a COVID-19 vaccine being offered since 2024.5. R49's EMR lacked documentation of a COVID-19 vaccine being offered since 2024.On 07/08/2026 at 12:10 PM, Administrative Staff A provided information for COVID-19 vaccines; she reported she did not have current consents/declinations for the residents. On 07/08/2026 at 01:50 PM, Administrative Staff A reported she was unsure if the facility offered the COVID-19 vaccine education to the staff. Consultant Staff HH (Regional VP Administrator) reported that when an employee was hired, Administrative Staff B provided education for the COVID-19 vaccine, and staff were offered to go to their own provider to receive a vaccine, and if they cannot receive a COVID-19 vaccine, the facility would provide them with one. On 07/08/2026 at 02:20 PM, Consultant Staff HH provided a copy of the PowerPoint slide that is used for the COVID education that was reviewed when a new hire was in orientation. The COVID-19 education PowerPoint educated on what COVID was, the symptoms, and to wear a mask or stay home. The PowerPoint lacked education about the COVID-19 vaccine and how to obtain one. Consultant Staff HH reported that it was completed verbally during the education. The facility's policy COVID-19 Vaccination dated 05/21/2021 documented the COVID vaccine offered to patients/residents and team members may be provided directly by the center or indirectly, such as through an arrangement with a pharmacy partner, local health department, or other appropriate health entity. All patients/residents and team members must be educated on the vaccine-specific COVID-19 Vaccine they are offered.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to notify the Long-Term Care Ombudsman in writing of Resident (R) 53's discharge from the facility. The facility failed to complete a discharge summary which included recapitulation of R6's stay and/or reconciliation of his medications following discharge.Findings included:1. Resident (R) 53's Entry Minimum Data Set (MDS), dated [DATE], documented the resident admitted to the facility on [DATE].R53's Discharge Return not Anticipated MDS, dated 05/07/2026, documented the resident's discharge from the facility to the community on 05/07/2026.R53's Electronic Medical Record (EMR) Social Service Progress Note documentation, dated 05/07/2026 at 01:30 PM, included that the resident does not want to stay at the facility. She left the facility against medical advice. Her EMR lacked documentation for notification of the Ombudsman of the resident's discharge from the facility. The facility was unable to provide the documentation upon request.On 07/07/2026 at 12:03 PM, Administrative Staff B reported she did not notify the Ombudsman of resident discharges from the facility.On 07/07/2026 at 02:00 PM, Social Service Staff X reported she was not responsible for notification of residents' discharges to the Ombudsman.On 07/08/2026 at 12:22 PM, Administrative Staff A confirmed the above and stated the facility had not notified the Ombudsman of residents' discharges from the facility prior to the survey.2. R6's admission MDS documentation, dated 05/05/2026, included the resident admitted to the facility on [DATE]R6's Electronic Medical Record (EMR) Progress Note (PN), dated 06/29/2026 at 01:53 PM, included orders received for discharge on [DATE].R6's EMR lacked a discharge summary which included recapitulation of R6's stay and /or reconciliation of his medications on discharge.On 07/07/2026 at 11:25 AM, Licensed Staff (LN) H reported that when residents were discharged from the facility to the community, the nurse should ensure the resident has discharge orders, complete a discharge assessment to recap the resident's stay and reconcile their medications, and document the disposition of the medications.On 07/07/2026 at 11:45 AM, Administrative Staff D reported Social Service Staff (SSD) X should open the discharge evaluation and set up a discharge plan for the residents. Upon review of R6's EMR, Administrative Nurse D confirmed the resident lacked a discharge summary to include a recap of her stay and/or reconciliation of R6's medications. The facility lacked a policy related to completion of a discharge summary to include the recapitulation of the resident's stay, reconciliation of medications, and/or notification of the ombudsman when residents are discharged to the community.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide necessary care and services for activities of daily living (ADLs) for Resident (R) 8, who was not showered for two weeks, and R25 had dirty fingernails.Findings included:- Review of the Electronic Health Record (EHR) revealed that R8 's diagnoses included left femur fracture/displacement (a traumatic bone break where two ends of the bone separate out of their normal position), Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), diabetes mellitus type II (when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), dysphagia (swallowing difficulty), and polyneuropathy (a neurological condition characterized by damage to multiple peripheral nerves simultaneously). R8's Significant Change Minimum Data Set (MDS), dated 04/29/2026, documented a Brief Interview for Mental Status (BIMS) of 15, indicating intact cognitive impairment. The Functional Abilities Care Area Assessment (CAA), dated 04/29/2026, documented R8 required substantial/moderate assistance with eating, showering, and shower room transfers. The CAA noted R8 fell on [DATE], resulting in a left hip fracture that required surgical intervention. R8's Care Plan for ADLs, dated 12/05/2024, instructed staff to provide substantial to moderate assistance with eating, showering, and shower transfers. The shower book at the nurses' station contained blank forms, and completed shower sheets had a shower schedule in the front of the book verifying R8's bath/shower days were scheduled for Tuesday AM and Friday PM. This shower book had completed shower sheets for 07/01/2026 – 07/06/2026. There were no completed shower sheets for R8. R8's EHR, under the bathing Tasks tab, did not have documented evidence that R8 received a bath or shower for the period between 06/19/2026 and 07/03/2026. Observation on 07/06/2026 at 11:46 AM revealed R8 sat in an open room watching television with other residents present. He wore a very worn navy sweatshirt and navy sweatpants with dirty white socks. His sweatshirt had an excess of tiny white skin flakes, and his hair appeared messy and uncombed. R8 had notable stubble on cheeks and chin. In an interview on 07/06/2026 at 03:05 PM, R8 said showers were scheduled for Tuesdays and Fridays. R8 stated he had not received a shower for almost two weeks. R8 stated there are times he refused his showers, but he did not receive a bath or shower at all the previous week. R8 also stated he likes to be clean-shaven, as he rubbed his chin and cheeks. On 07/08/2026 at 04:05 PM, an interview with Administrative Nurse D stated she expected that all residents receive at least two showers per week. She stated if nursing or other staff bring to her attention that a resident is refusing and/or not getting their showers, she will personally speak with the resident to discuss why this might be happening. During an interview with Consultant II on 07/08/2026 at 04:10 PM, Consultant II stated that shower sheets are not an appropriate form of documentation and that the Tasks in Point Click Care should be (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	utilized as the exclusive tool for reference. - R25's Electronic Medical Record (EMR) revealed diagnoses of parkinsonism (a slowly progressive neurologic disorder characterized by resting tremors, shuffling gait, muscle rigidity, and weakness) and Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure). R25's 11/28/2025 Significant Change Minimum Data Set (MDS) documented a Brief Interview for Mental Status could not be completed as R25 was rarely/never understood) Staff interview completed, and R25's MDS documented she had severely impaired cognition. R25's MDS documented that she required supervision assistance for personal hygiene. R25's 12/05/2025 Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) lacked a documented CAA note. R25's 05/06/2026 Quarterly MDS documented a BIMS score of four, indicating severely impaired cognition. R25's MDS documented that she required maximal assistance for personal hygiene. R25's Care Plan, dated 05/11/2026, documented that staff were instructed to provide maximal assistance to R25 for her personal hygiene. On 07/06/2026 at 10:33 AM, R25 was seated in her wheelchair with closed eyes; R25's nails had a brown substance under them. R25 would not answer any questions. On 07/06/2026 at 02:15 PM, R25 was eating some vanilla wafers while sitting in her wheelchair in the television lounge. R25's fingernails had a brown substance under her nails. On 07/07/2026 at 08:01 AM, R25 was seated in the dining room in her wheelchair; R25's fingernails had a brown substance under her nails. On 07/08/2026 at 07:38 AM, R25 was seated in her wheelchair in the dining room with her eyes closed, and her fingernails had a brown substance under the nails. On 07/08/2026 at 09:03 AM, Certified Nurse Aide (CNA) N stated that if the staff noticed a resident had dirty, unclipped nails, staff would take care of the nails on their shower day, and the staff should check the resident's nails every morning. CNA N reported that R25 does not refuse care. On 07/08/2026 at 12:01 PM, Licensed Staff (LN) G reported that the residents should have their nails cleaned when they are seen dirty and especially on shower day. On 07/08/2026 at 03:36 PM, Administrative Nurse D expected staff to clean nails as needed and on scheduled shower days. The facility did not provide a policy for activities of daily living for a dependent resident.

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	07/08/2026

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

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure a safe environment free from accident hazards for Resident (R) 25 when staff failed to respond to R25's requests for help and failed to provide foot pedals when staff propelled the wheelchair. Findings included:- R25's Electronic Medical Record (EMR) revealed diagnoses of parkinsonism (a slowly progressive neurologic disorder characterized by resting tremors, shuffling gait, muscle rigidity, and weakness) and Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure). R25's 11/28/2025 Significant Change Minimum Data Set (MDS) documented a Brief Interview for Mental Status could not be completed as R25 was rarely/never understood) Staff interview completed, and R25's MDS documented she had severely impaired cognition. R25's MDS documented she had one non-injury fall, and she required total staff assistance with wheelchair mobility. R25's 12/05/2025 Falls Care Area Assessment (CAA) lacked a documented CAA. R25's 05/06/26 Quarterly MDS documented a BIMS score of four, indicating severely impaired cognition. R25's MDS documented she had one non-injury fall, and she was independent with wheelchair mobility.R25's Care Plan, dated 05/11/2026, instructed staff that R25 was independent with locomotion in her manual wheelchair. R25's Care Plan, dated 07/07/2026, lacked documentation regarding foot pedals. R25's Fall Risk Screen, dated 01/09/2026, documented she was at high risk for falls with a score of 20.0. R25's Weekly Nurses Note, on 07/08/2026 at 02:15 AM, documented R25 propels self in wheelchair throughout the facility. On 07/06/2026 at 10:24 AM, R25 was propelled out of the restroom by Certified Nurse Aide (CNA) Q near the nurse station; no foot pedals were on her wheelchair, and her socked foot hit the floor one time when pushed to the television lounge. On 07/07/2026 at 11:25 AM, R25 was seated in her wheelchair holding onto the back of a blue recliner chair, pulling her buttocks forward on the wheelchair seat, calling out for help. CNA Q walked by the resident. On 07/07/2026 at 11:33 AM, CNA Q propelled R25 down the hallway from the television lounge to the dining room. No foot pedals were noted on R25's wheelchair; at one time, CNA Q pushed the chair and let it go and skipped towards R25's wheelchair. On 07/08/2026 at 11:16 AM, CNA Q reported that R25 was able to propel herself in the wheelchair and that she should not push her in the wheelchair without foot pedals. CNA Q reported she was just trying to get R25 to her meals. On 07/08/2026 at 12:01 PM, Licensed Staff (LN) G reported that the residents should always have foot pedals on when the staff is pushing them. On 07/08/2026 at 03:36 PM, Administrative Nurse D expected staff to use foot pedals when transferring a resident. The facility did not provide a policy regarding foot pedals.

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	07/08/2026

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

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on interview and record review the facility failed to offer and provide or obtain an informed declination for the influenza vaccine (vaccine designed to prevent highly contagious viral infection) form to Resident (R) 5, and R8. Findings included:1. R5's Electronic Medical Record (EMR) documented that no education was provided when she received the influenza vaccine on 11/07/2025. Consent was documented as confirmed. 2. R8's EMR documented no education was provided when he declined the influenza vaccine on 10/31/2025. The facility was unable to provide a signed declined Patient/Resident Declination/Authorization Form (Flu).On 07/08/2026 at 12:10 PM, Administrative Staff A provided information for influenza vaccine of a list of handwritten residents' names, a copy of the sticker of the influenza vaccine lot number, expiration date, and site the vaccine was administered. Administrative Staff A reported she had no current signed consents or declinations for the resident's influenza vaccines. On 07/08/2026 at 01:00 PM, Administrative Staff A reviewed the EMR for the resident's influenza vaccines that were documented when given or declined and reported that the nurse should have documented yes for education when administering the vaccine or when the resident refused. The facility policy Influenza Vaccination Policy dated 11/01/2016, documented the facility would obtain and document consent or declination for the influenza vaccine using the Patient/Resident Declination/Authorization Form. The facility would discuss with the resident and/or responsible party information regarding influenza and influenza vaccine as noted on the Patient/Resident Declination/Authorization Form.