STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175254	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Diversicare of Sedgwick	712 N Monroe Avenue, Box 49 Sedgwick, KS 67135

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. (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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 48 residents. The sample included six residents with one resident reviewed for involuntary discharge. Based on interviews and record review, the facility failed to ensure Resident (R) 1's Electronic Health Record (EHR) contained physician documentation of the rationale for the involuntary immediate discharge. This placed the resident at risk for impaired rights and inappropriate discharge. Findings included: - R1's EHR documented diagnoses that included Huntington's disease (a rare abnormal hereditary condition characterized by progressive mental deterioration, a disabling central nervous system movement disorder), anxiety (a mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), history of suicidal behavior and major depressive disorder (MDD - a major mood disorder that causes persistent feelings of sadness).R1's Census log documented Discharge Paid dated 06/26/25, and Stop [NAME] dated 06/27/25.R1's Significant Change Minimum Data Set (MDS) dated [DATE] documented, per staff interview, R1 had moderately impaired cognition. The assessment documented verbal behaviors towards others and behaviors not towards others occurred one to three days during the look-back period. The assessment documented these behaviors put the resident at risk for physical illness and/or injury and interfered with care. R1 was dependent on staff for personal hygiene, shower/bathing, toileting hygiene, and oral hygiene. R1 required substantial/maximal assistance for application of footwear, and upper and lower body dressing. R1 required supervision/touching assistance for eating. R1 required substantial/maximal assistance for all transfers and was always incontinent of bowel and bladder.R1's Behavioral Symptoms Care Area Assessment (CAA) dated 05/29/25, documented R1 had physical harm to himself related to hitting his head against the wall and placing himself on the floor.R1's Discharge - Return Anticipated Minimum Data Set (MDS) dated [DATE] documented R1 had an unplanned discharge from the facility to an inpatient psychiatric facility. The assessment documented a Brief Interview of Mental Status interview could not be completed, though per staff assessment, R1 had severely impaired cognition. The assessment documented physical, verbal, and other behaviors towards himself and others, with rejection of care, which occurred one to three days during the look-back period.R1's EHR Physician Orders documented an order to transfer/discharge R1 to an Emergency Department (ED) due to acute psychosis (any major mental disorder characterized by a gross impairment in reality perception) with a suicide attempt, dated 06/26/25, from Physician Extender EE. The order was entered by Administrative Nurse D.R1's EHR Progress Notes documented the following notes:On 06/09/25 at 08:17 AM, staff documented R1 was restless, anxious, and agitated. Non-medicinal interventions were attempted but unsuccessful, and R1 became physically violent with staff. As-needed (PRN) medications were given, and 1:1 observation continued.On 06/14/25 at 02:45 PM, staff documented that at approximately 02:00 PM, R1 was verbally aggressive and threatened physical violence to staff. PRN medications were administered along with non-medicinal interventionsOn 06/21/25 at 10:52 AM, staff documented R1 had increased restlessness, anxiety, and aggression with physical violence and verbal aggression towards staff. PRN medications were administered with non-medicinal interventions in place.On 06/25/25 at 12:15 AM, staff documented R1 suddenly became physically and verbally aggressive towards staff, which included expletives and insults. R1 placed himself on the floor and started banging his head on the floor. Staff unsuccessfully attempted to redirect R1, and PRN medications were administered.On 06/25/25 at 04:18 PM, Physician DD documented an exam of R1, which noted R1 had a sitter for 1:1 observation due to recent behaviors. Physician DD documented staff reported increased behaviors and noted R1 had been seen by a psychiatric provider who was no longer at the facility; a new psychiatric provider had been located, but R1 had not been evaluated by the new psychiatric provider. Physician DD documented R1 was very hard to redirect with his behaviors.On 06/25/25 at 08:40 PM, staff documented a Weekly Nurses Note that documented R1 continued with 1:1 staff supervision related to the history of suicide attempts and suicidal ideations (thoughts or ideas about dying by suicide). R1 continued to have episodes of aggression and anxiety with verbal and physical abuse towards self and others.On 06/26/25 at 04:22 PM, staff documented at approximately 01:50 PM, R1 suddenly got up and forcefully removed the blinds from the window and stated he wanted to kill himself. He then placed himself on the ground and began hitting his head against the floor. Staff attempted redirection and placed cushions around him to prevent injury. R1 refused to surrender the window blinds to staff or allow staff to assist him off the floor. At approximately 02:00 PM, the Licensed Nurse (LN) provided PRN medications to help calm R1, but the medications were