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	09/23/2025

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. The facility reported a census of 47 residents. The sample included 13 residents with five residents reviewed for unnecessary medications. Based on interview and record review, the facility failed to ensure informed consent including purpose, risks versus benefits, and expected therapeutic benefits for the use of antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), anxiolytic (medication used to treat symptoms of anxiety) and other psychotropic medications (drugs that affect the brain and nervous system to treat mental illnesses)) for one resident, Resident (R)3. Findings included:- R3's Electronic Medical Record (EMR) revealed the following diagnoses: anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), major depressive disorder (MDD- major mood disorder that causes persistent feelings of sadness), and insomnia.R3's EMR documented the following physician's orders:Latuda (an antipsychotic medication), 40 milligrams (mg), by mouth (PO), every day (QD), for a diagnosis of MDD, ordered 07/28/25.Pristiq (an antidepressant medication), 100 mg, PO, QD, for a diagnosis of depression, ordered 07/28/25.Remeron (an antidepressant medication), 15 mg, PO, QD, for a diagnosis of insomnia, ordered 07/28/25.Xanax (an antianxiety medication), 0.25 mg, PO, twice daily for a diagnosis of anxiety, ordered 07/28/25.R3's EMR lacked documentation of informed consent for the medications.On 09/22/25 at 03:11 PM, Administrative Nurse D stated the expectation was for the nursing staff to complete a psychotropic informed consent with any dose change or before the initiation of a psychotropic medication.The facility policy for Resident's Rights and Quality of Life, effective 05/01/12, included: All residents in the facility have the right to be informed in advance about care and treatment and any changes in care or treatment.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 47 residents; the sample included 15 residents. Based on interviews, record review and observation, the facility failed to ensure a safe, clean home-like environment in the resident's rooms and facility common areas. Findings included: - Observed on 09/21/25 at 09:04 AM, Resident (R)1's room had trim-molding around the base of the wall peeled off and paint on the wall peeled off, exposing sheetrock; the inside of the room door had exposed wood and splintered areas.Observed on 09/21//25 at 09:48 AM, R17 and R8's bathroom door had multiple areas with paint missing and exposed wood, and the door frame to the bathroom had areas of peeled paint that exposed bare metal.Observed on 09/21/25 at 10:49 AM, in R9's room, the corner of the wall, by the floor, next to the door frame, trim-molding was missing and exposed a hole with loose sheetrock. The area where the wall met the ceiling above the windows had bubbled, missing, and peeling paint. The window blinds were bent in multiple places. The bathroom door had chipped paint and an area that was broken, approximately three inches by one inch, just above the lower door hinge, with exposed and splintered wood.Observed on 09/21/25 at 11:32 AM, R24's room had various areas where the walls meet the ceiling, and paint had separated, cracked, and peeled. One wall, next to the bead, paint had peeled away in several places and exposed sheetrock. The blinds on the windows were dusty, had broken and bent slats.Observed on 09/21/25 at 11:51 AM, the blinds on R46's windows had numerous bent slats, and the room door had multiple areas splintered and exposed wood.Observed on 09/22/25 at 01:25 PM, during the environmental tour with Administrative Staff A, Maintenance U, and Maintenance V, the four air conditioning (A/C) vents in the ceiling of the 200 hallway appeared to have dark black and gray spots covering them. Upon closer investigation, the dark spots appeared to have a fuzzy appearance and be of an unknown organic substance. Several areas of the ceiling, around the vents, appeared to have this same substance.Observed on 09/22/25 at 01:45 PM, while further performing the environmental tour with Administrative Staff B and Administrative Staff A, the A/C vent and the fire suppression sprinkler head in the ceiling of the facility lobby area appeared to have an unknown organic substance on, back, and gray in color with fuzzy appearance, and around them, to include the ceiling. Both Administrative Staff B and Administrative Staff A stated that they were unaware of the substance on the vents and ceiling, and further stated that it was a concern.Observed on 09/22/25 at 02:53 PM, two fluorescent lights in the 100 hallway were partially hanging down from the ceiling, and the four A/C vents in the 100 hallway ceiling appeared to have an unknown organic substance that was black and gray in color with a fuzzy appearance. This substance appeared on the ceiling around the vents, also.Observed on 09/23/25 at 7:27 AM, upon entering the facility, in the main lobby area, the A/C vent appeared to have been cleaned, and the ceiling around the sprinkler head and vent appeared to have been freshly painted, along with the eight vents and ceiling areas in the 100 and 200 hallways.Observed on 09/23/25 at 09:05, the ceiling in the main lobby area of the building, around the fire detection device, was a black and fuzzy appearing, unknown organic substance. Administrative Staff A stated that he was unaware of this spot in the ceiling and confirmed it appeared to be of an unknown organic substance.The contract, signed and dated on 05/01/13, documented that Diversicare of Chanute contracted housekeeping and laundry services to an outside group. The contract did not list the housekeeping duties that would be covered and performed by the contracted housekeeping staff.The Medical Director Services Agreement, signed by Administrative Staff C and Consultant GG and dated 06/23/16, documented that the medical director would help the facility provide a safe and caring environment and help promote employee health and safety.Review of records showed a facility Performance Improvement Project (PIP) that addressed the (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	facility items that do not contribute to a homelike environment and was marked as ongoing.On 09/22/25 at 01:27 PM, Administrative Staff A stated that the substance on the vents and ceiling of the 200-hall did not appear to be dirt, dust, or rust, and further stated that the substance was concerning. Maintenance U verified that the substance did not appear to be dust or dirt and further stated that it was a concern.On 09/22/25 at 01:35 PM, Maintenance U stated that maintenance and environmental repairs are tracked through The Equipment Lifecycle System (TELS- a building and asset management platform for the long-term care and senior living industries) via work-order.On 09/22/25 at 02:55, Administrative Staff B stated that she was unaware of the lights that hung from the 100-hallway ceiling and was unaware of the substance in and around the ceiling and A/C vents in the 100-hallway. She further stated that the substance appeared organic. Administrative Staff B also stated that the facility had a PIP that identified homelike environmental concerns about the resident rooms that included doors, window blinds, wall and ceiling paint, but was unaware of the hole in the wall of R9's room. She also stated that the roof and main A/C units for the building had recently been repaired and replaced.On 09/22/25 at 03:10 PM, Administrative Staff B stated that she expected staff to be vigilant and identify and report any maintenance or environmental issues, and for the maintenance department to reduce and eliminate any hazards quickly and correctly.On 09/23/25 at 7:49 AM, Maintenance U stated that he removed the A/C vents in the hallways, and the internal ducts appeared to be clean, the evening of 09/22/25.On 09/23/25 at 08:31 AM, Administrative Staff A reported that the administrative and maintenance team decided that an outside contractor was not required to clean or identify the unknown organic substance in and around the ceiling A/C vents. He further stated that on the evening of 09/22/25, Maintenance U and Maintenance V removed the nine A/C vents that had the unknown organic substance, cleaned them, and cleaned the ceiling around the vents. He also reported that the residents were not in the hallway or immediate area when the vents and ceilings were cleaned, and the facility had started a working plan to correct and prevent further environmental concerns, and that an internal audit had been performed related to current respiratory illness for all residents, and none had been identified.On 09/23/25 at 10:04 AM, Maintenance V stated that the resident room Packaged Terminal Air Conditioners (PTAC) are maintained, at a minimum, monthly, and the main building A/C unit was included with this maintenance schedule, but that did not include cleaning the vents in the building. Maintenance U stated that housekeeping services were contracted out to a vendor, and that they were responsible for the cleaning of all vents. Administrative Staff A verified that housekeeping services were contracted out.On 09/23/25 at 10:48 AM, Housekeeping W stated that she did not know who was responsible for cleaning the building vents and did not know the last time they were cleaned.On 09/23/25 at 10:55 AM, Housekeeping X stated that housekeeping services were responsible for dusting the vents in the building, not cleaning them, and that high-surface dusting was performed monthly, and there was a calendar maintained to track that the high-surface dusting was performed. She further stated that she knew the vents were cleaned last week.On 09/23/25 at 11:30 AM, Administrative Staff A and B provided housekeeping records, with a cleaning checklist, that revealed the housekeeping staff performed daily cleaning duties for the resident rooms only. Administrative Staff B stated that there was no checklist or record maintained for the main building areas to be cleaned; there was only a calendar maintained that showed who was responsible for those duties on each day. The facility policy Resident's Rights and Quality of Life, dated 05/01/12, documented that residents had the right to receive services in a facility environment that is safe, clean, and comfortable.

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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** The facility reported a census of 47 residents; the sample included 15 residents with one resident reviewed for activities of daily living (ADLS). Based on observation, interview, and record review, the facility failed to provide nail care for the one sampled resident, Resident (R)5. Findings included:- R5's Electronic Medical Record (EMR) revealed a diagnosis of dementia (a progressive mental disorder characterized by failing memory and confusion).R5's Quarterly Minimum Data Set, dated [DATE], documented that the resident had a Brief Interview for Mental Status score of three, indicating severe cognitive impairment. She required partial to moderate assistance with showering and setup assistance for personal hygiene.R5's Care Plan revised 08/14/25, instructed staff the resident had dementia and required assistance with all ADL.On 09/22/25 at 09:19 AM, R5 sat in her wheelchair in the doorway of the dining room. The resident had long, dirty fingernails.On 09/22/25 at 09:21 AM, Certified Nurse Aide (CNA) M stated that staff clean the residents' fingernails on their shower days.On 09/22/25 at 12:45 PM, Certified Medication Aide (CMA) R stated residents' fingernails were cleaned on their shower days.On 09/22/25 at 12:51 PM, Administrative Nurse E stated it was the expectation for staff to clean residents' fingernails on shower days.The facility policy for Resident's Rights and Quality of Life, effective 05/01/12, included: All residents in the facility have the right to a dignified existence.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. The facility reported a census of 47 residents. Based on observation, record review and interview, the facility failed to display accurate, and identifiable staffing information, on a daily basis, for the 47 residents who resided in the facility.- Review of the facility's Daily Staffing sheets, 08/22/25 through 09/21/25, revealed that the actual hours worked per shift had not been completed on the daily staffing sheets. On 09/22/25 at 12:41 PM, Administrative Nurse D confirmed the Daily Staffing sheets lacked the actual hours worked per shift.The facility did not provide a policy.