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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175235	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Diversicare of Larned	1114 W 11th Street Larned, KS 67550

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 44 residents. The sample included 12 residents with one reviewed for missing personal property. Based on observation, record review, and interview, the facility staff failed to document and promptly resolve Resident (R) 7's grievance when she reported to staff she had missing clothing items. Findings included:- R7's Electronic Medical Record (EMR) documented R7 had diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion) and depression (a mood disorder which causes a persistent feeling of sadness and loss of interest). R7's Significant Change in Status Minimum Data Set (MDS), dated [DATE], documented R7 had a Brief Interview of Mental Status (BIMS) score of eight, which indicated moderately impaired cognition. The MDS documented R7 was dependent and required substantial/maximal assistance for activities of daily living (ADLs). A review of the Resident Grievance/Complaint Log from 10/1/25 to present, provided by Social Services X, lacked documentation of R7's grievance regarding missing clothing items. There were three concerns of missing items, and two had been resolved favorably. An interview on 01/06/26 at 02:30 PM, R7's representative stated R7 had two brand new sweaters given to her as a Christmas gift, with the price tags still on them. R7's representative stated she informed an (unnamed) nurse aide and Administrative Staff A in December as soon as she discovered both sweaters were missing from R7's closet, though she was unsure of the exact date. On 01/08/26 at 10:26 AM, Administrative Staff A stated he was aware of the missing sweaters but said it probably was not documented anywhere. He said the issue was discussed with R7's representative multiple times. Administrative Staff A stated the situation remained unresolved and said despite the ongoing nature of the situation and the lack of documentation, the facility had full intentions of resolving the situation. On 01/08/26 at 10:35 AM, Social Services X verified she was notified of R7's missing sweaters at the Christmas party. Social Services X said staff were alerted to look for the sweaters at the time, though they were not found. Social Services X said the staff found a similar sweater and placed it into the resident's closet, but the staff did not notify the resident's representative. Social Services X stated she did not realize the missing sweaters were an ongoing issue. Social Services X verified an official grievance had not been logged regarding the situation. On 01/08/26 at 11:02 AM, Housekeeping/Maintenance U verified she was notified about R7's missing sweaters at the Christmas party. She said she looked in the laundry and other residents' closets but was unable to find them. Housekeeping/Maintenance U stated she found a black and maroon sweater, not exactly fitting the description of the missing sweaters with R7's name written on the tags, so they were put in the resident's closet. She stated she thought the issue was resolved. The facility's policy Customer Concern/Grievance Policy dated July 2018, states the resident (or representative) will have a prompt response, with follow-up communication within 48 hours, after the Administrator conducts a full investigation and composes a plan of action completed (with the customer) and have the (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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	plan documented, which involves a resolution.

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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. The facility reported a census of 45 residents. The sample included 12 residents with two residents reviewed for facility discharge. Based on interview and record review e facility failed to complete a recapitulation of Resident (R) 47's stay in the facility. Findings included:- R47's Electronic Medical Record (EMR) revealed the following diagnoses: atherosclerotic heart disease (heart disease) and type two diabetes (a disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in abnormal metabolism of carbohydrates and elevated levels of glucose in the blood and urine). R47's 10/02/25 admission Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) of 15, which indicated intact cognition. The MDS recorded R47 required supervision or touching assistance with toileting, and substantial/maximal assistance with bathing. R47's Care Plan identified a self-care deficit related to recent surgery. R47's endurance was low from the surgery; R47 had difficulty with ambulation over long distances and directed staff to offer a wheelchair and assist the resident to the dining room if needed. Staff were to provide supervision and touching assistance with the following tasks: toileting, showers, lower/upper dressing, footwear, sit-to-stand transfers, and ambulation with a front-wheeled walker. R47's Progress Note on 11/23/25 at 4:47 PM indicated R47 left the facility with a family member at approximately 4:45 PM with his four-wheeled walker, personal belongings, and medication. R47 ambulated independently with a walker out of the facility. R47's clinical record lacked evidence of a completed recapitulation outlining the course of his facility. On 01/08/26 at 08:00 AM, Social Services X revealed she sends out the monthly fax to the Ombudsman with discharges from the facility or hospitalization of our residents. On 01/08/26 at 08:27 AM, Administrative Staff D revealed the facility does not have a discharge summary system and verified the facility did not fill out the discharge summary or recapitulation of R47's stay. The facility failed to provide a policy on discharge.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. The facility identified a census of 44 residents. The sample included 12 residents. Based on observation, interview, and record review, the facility failed to develop a comprehensive care plan for Resident (R) 1's antipsychotic (a class of medications used to treat major mental conditions which cause a break from reality) medication and R31's activities of daily living (ADLs) for a dependent resident. Findings included:- R1's Electronic Medical Record (EMR) revealed diagnoses of bipolar disorder (a major mental illness which causes people to have episodes of severe high and low moods) and depression (a mood disorder which causes a persistent feeling of sadness and loss of interest). R1's 05/09/25 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) of 13, which indicated intact cognition. R1's MDS documented no behaviors and minimal depression. R1's MDS recorded R1 received an antianxiety (a class of medications which calm and relax people) and an antidepressant (a class of medications used to treat mood disorders) in the look-back period. R1's 05/12/25 Psychotropic Drug Use Care Area Assessment (CAA) documented R1 triggered related to use of psychotropic medications to manage psychiatric condition. A care plan will be developed and/or reviewed to monitor the effectiveness of psychotropic medications. R1's 10/24/25 Quarterly MDS documented a BIMS score of 15, which indicated intact cognition. R1's MDS revealed R1 received an antianxiety and antidepressant medication in the look-back period. R1's 01/06/26 Care Plan lacked documentation for an antipsychotic medication. R1's Physician's Orders documented Seroquel (antipsychotic medication) 50 milligrams (mg), give one tablet, by mouth, daily for bipolar, date ordered 11/20/25, date discontinued 12/04/25. R1's Physician's Orders documented risperidone (antipsychotic medication) 0.25 mg, give one tablet twice a day for behaviors, date ordered 12/04/25. R1's Progress Notes, documented 11/20/25 at 11:53 AM, noted R1 was assessed by the provider who gave new orders to increase the Seroquel to 50 mg at bedtime. R1's Physician Notes on 12/04/25 documented R1 had been having aggressive behaviors and a lot of anger recently. She did have a history of bipolar disorder and anxiety. She was started on Seroquel previously, but the staff stated this had not made a difference in her behavior. R1 reported she was pushing her walker and pushing other things because she was mad. Staff reported she was very angry and said mean things to others. During an observation and interview on 01/06/26 at 09:33 AM, R1 ambulated independently down the hallway with her walker. R1 reported she was quite anxious about a surgery which had to be rescheduled from 01/08/25 to 01/29/25. R1 had a flat affect at first and refused an interview, but then she said she would interview. R1 reported she can get very angry quickly for no reason. She reported she really had no one here to talk to her about her feelings. During an observation on 01/07/26 at 08:08 AM, R1 was seated in her chair in the dining room, drinking coffee and socializing with other peers. During an interview on 01/08/26 at 10:26 AM, Licensed Nurse (LN) I reported care plans were developed and updated by Administrative Nurse D. During an interview on 01/08/26 at 10:52 AM, Administrative Nurse D reported R1's antipsychotic medications should have been documented on the care plan within twenty-four hours. The facility did not provide a policy for care plan development. - R31 's Electronic Medical Record (EMR) revealed diagnoses of 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), hemiparesis/hemiplegia (weakness and paralysis on one side of the body), and dementia (a progressive mental disorder characterized by failing memory and confusion). R31's 05/13/25 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderately impaired cognition. R31's MDS documented she had an impairment in her upper and lower extremities on one side. R31's MDS documented she required total assistance with all activities of (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	daily living (ADL) and needed setup for eating. R31's 05/14/25 Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) documented R31 triggered related to assistance required with ADLs. R31's 11/07/25 Quarterly MDS documented a BIMS score of five, which indicated severely impaired cognition. R31's MDS documented impairment in her upper and lower extremities on one side. R31's MDS documented she required total assistance with all ADLs except she needed setup for eating. R31's 01/06/26 Care Plan lacked any care plan regarding facial hair and nail care. During an observation on 01/06/26 at 11:30 AM, R31 sat in her wheelchair in the facility lounge. She had visible black and white colored facial hair approximately one-quarter inch in length above her upper lip. R31's fingernails were long on her right hand, and she had visible brown colored residue under most of her fingernails. During an observation on 01/07/26 at 08:05 AM, R31 sat in her wheelchair in the facility lounge. She had visible black and white colored facial hair approximately one-quarter inch in length above her upper lip. R31's fingernails were long on her right hand, and she continued to have visible brown colored residue under most of her fingernails. During an observation on 01/08/26 at 07:45 AM, R31 sat in her wheelchair in the facility lounge. R31's facial hair and nails were unchanged from the 01/06/25 and 01/07/25 observations. During an interview on 01/07/26 at 03:54 PM, Certified Nurse Aide (CNA) N reported she would read the resident's care plan to know what care was required for a resident. During an interview on 01/08/2026 at 10:26 AM, Licensed Nurse (LN) I reported care plans are developed and updated by Administrative Nurse D. During an interview on 01/08/26 at 10:52 AM, Administrative Nurse D reported R31's Care Plan did not address any personal hygiene staff needed to provide. Administrative Nurse D reported she expected the care plans to be accurate so care would be provided to the residents. The facility did not provide a policy for care plan development.

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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. The facility reported a census of 44 residents. The sample included 12 residents with one resident reviewed for activities of daily living (ADLs). Based on observation, interviews, and record review the facility failed to offer and provide assistance with nail care and facial hair removal for Resident (R) 31. Findings included:- R31 's Electronic Medical Record (EMR) revealed diagnoses of 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), hemiparesis/hemiplegia (weakness and paralysis on one side of the body), and dementia (a progressive mental disorder characterized by failing memory and confusion). R31's 05/13/25 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderately impaired cognition. R31's MDS documented she had an impairment in her upper and lower extremities on one side. R31's MDS documented she required total assistance with all ADL, except she required setup for eating. R31's 05/14/25 Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) documented R31 triggered related to assistance required with ADLs. R31's 11/07/25 Quarterly MDS documented a BIMS score of five, which indicated severely impaired cognition. R31's MDS documented an impairment in her upper and lower extremities on one side. R31's MDS documented she required total assistance with all ADLs, except she required setup for eating. R31's 01/06/26 Care Plan lacked any care plan regarding facial hair and nail care. Review of R31's Bath and Shower Report sheets dated from 11/05/25 through 12/31/25 revealed facial hair removal was checked off as no, indicating it was done on all 13 shower report sheets. Additionally, R31's fingernails short/trimmed was checked off yes on 11/05/25 and checked off no for the remaining 12 shower reports. The facility lacked the shower reports for January 2026. During an observation on 01/06/26 at 11:30 AM, R31 sat in her wheelchair in the facility lounge. She had visible black and white colored facial hair approximately one-quarter inch in length above her upper lip. R31's fingernails were long on her right hand, and she had visible brown colored residue under most of her fingernails. During an observation on 01/07/26 at 08:05 AM, R31 sat in her wheelchair in the facility lounge. She had visible black and white colored facial hair approximately one-quarter inch in length above her upper lip. R31's fingernails were long on her right hand, and she continued to have visible brown colored residue under most of her fingernails. During an observation on 01/08/26 at 07:45 AM, R31 sat in her wheelchair in the facility lounge. R31's facial hair and nails were unchanged from the 01/06/25 and 01/07/25 observations. During an interview on 01/07/26 at 09:52 AM, Certified Nurse Aide (CNA) M reported she would assist R31 with ADLs around 06:15 AM every day. During an interview on 01/07/26 at 03:54 PM, CNA N reported the staff would complete nail care and facial hair removal on bath days or as needed. CNA N reported R31 received a shower on Wednesday and Saturday afternoon shifts. During an interview on 01/08/26 at 10:26 AM, Licensed Nurse (LN) I stated she expected the CNAs to shave and complete nail care for the residents who required assistance. During an interview on 01/08/26 at 11:12 AM, Administrative Nurse D revealed she expected the staff to shave and complete nail care for residents every shower day or as needed. The facility did not provide a policy for ADL care for a dependent resident.

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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 44. Based on observation, interview and record review the facility failed to provide adequate infection control practices related to 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), hand hygiene and sanitizing shared equipment. Findings included:- Initial tour of the facility on 01/06/26 at 08:00 AM revealed a lack of visible signage to identify residents who required EBP. The facility had no visible setup for personal protective equipment (PPE) readily accessible to staff to apply before entering residents' rooms to provide direct care. During an observation 01/07/26 at10:16 AM, Licensed Nurse (LN) J and LN G entered the Resident (R) 2's room to provide catheter (tube inserted directly into the body to drain urine) care. The room lacked signage to indicate R2 required EBP. R2's room lacked the required EBP personal protective equipment (PPE) (gowns). There were gloves available in the room. R2's catheter bag laid on the floor. LN J picked up the catheter bag from the floor and hung it on the low bedrail, where it remained in direct contact with the floor. She washed her hands, applied gloves, and proceeded to provide catheter care. She cleaned the resident's catheter insertion site with gauze. The gauze was soaked with saline in a cup. LN J reached into the cup for saline-soaked gauze three times, wearing the same soiled gloves, each time continuing to use the gauze to clean the catheter insertion site. During an observation on 01/07/26 at 09:44 AM, Certified Nurse Aide (CNA) P and CNA M assisted R31 to bed with a mechanical lift. CNA M undressed R31's lower half and reported to CNA P that R31 was incontinent. CNA P opened a drawer with her gloved hands and got items out of the drawer, then proceeded to provide incontinent care to R31. Wearing the same gloves, CNA P sprayed peri wash directly on R31's perineum, then wiped with a wet wipe from a container while R31 remained on the soiled wet brief. Staff assisted R31 onto her left side. CNA P removed her gloves, then took another pair out of her pocket and applied them, without performing hand hygiene. CNA P cleaned R31 with a wet wipe, then applied a new brief and removed her gloves. Without performing hand hygiene, CNA P assisted R31 with positioning in bed and then used hand sanitizer. CNA P then picked up the bag of trash and took the trash as well as the mechanical lift out of the room. CNA P placed the lift in the hallway but did not sanitize it. CNA M finished placing the fall mat next to R31's bed, lowered the bed, then washed her hands and left the room. In an interview on 01/07/26 at 10:10 AM, CNA Q reported the staff probably did not always sanitize the mechanical lifts as they should. He reported the sanitizing wipes were stored in the biohazard rooms or clean rooms. During an interview on 01/08/26 at 07:55 AM with CNA P and CNA M, CNA P reported she would normally wash her hands when she changed her gloves and said she should have changed her gloves when she gathered supplies. CNA M reported they normally do not wipe off the lift after use. On 01/07/26 at 10:36 AM, LN I confirmed she did not remove her gloves and wash her hands before reapplying gloves. She said R2's catheter bag was directly on the floor and should have been changed to prevent cross-contamination and infection. LN I confirmed R2's room lacked signage to indicate EBP were required, and said none of the residents in the facility were set up for EBP. On 01/08/26 at 10:24 AM, Administrative Nurse D confirmed the catheter bags should not be placed directly on the floor, and if the bag and/or tubing come in direct contact with the floor, it should be replaced to prevent cross-contamination and infection. Administrative Nurse D confirmed none of the residents were identified as requiring EBP at the initiation of the survey. She reported four residents with indwelling catheters and one with wounds which should have EBP with readily accessible PPE and signage on the door to make staff aware. She stated staff should sanitize the lifts between resident use and perform appropriate hand hygiene to prevent cross-contamination and infection. The facility's (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Infection Control Guide dated 2025 included EBP referred to the expanded use of PPE and use of gown and gloves during high contact resident care activities which provide opportunities for transmission of multiple drug-resistant organisms (MDRO) to staff hands and clothing. MDROs may be indirectly transferred from resident to resident during high-contact care activities. Nursing home residents with wounds and indwelling medical devices were at especially high risk of both acquisition of and colonization of MDRO. Laminated signs should be placed on the resident's door to remind visitors and healthcare workers of needed precautions.

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F 0921 Level of Harm - Potential for minimal harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. The facility reported a census of 44 residents. Based on observation, interview and record review the facility failed to provide a safe, functional, and sanitary environment in the laundry area. Findings included:- The laundry tour on 01/08/2026 10:54 AM, with Laundry Staff U, Consultant GG, revealed the following concerns:A large yellow trash bin full of trash, without a cover, sat next to the washing machine.The laundry room ceiling had a brown discolored area adjacent to peeling paint and a strip of unfinished plaster without paint, approximately four feet by 10 inches above the dump tank.The folding room ceiling had a brown water stain approximately two feet by two inches along the junction of the ceiling to the wall over the folding table.On 01/08/2026 at 11:10 AM, Maintenance Staff V confirmed the above findings and reported the stains had occurred when the pipes froze. He stated he did not have a plan to repair the areas noted above.The facility policy Infection Control, dated 5/2025, documentation included the center's infection control policies and practices, which are intended to facilitate maintaining a safe, sanitary, and comfortable environment for team members.