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. **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, (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	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 ineffective. At approximately 02:05 PM, Administrative Nurse D was notified of the situation. At approximately 02:10 PM, R1 began to wrap the window blinds around his neck and continued to express a desire to kill himself. When staff intervened, R1 became physically aggressive and was violent towards staff. At approximately 02:42 PM, Emergency Medical Services (EMS) was called. Staff were able to safely place R1 in his bed prior to EMS arrival. When EMS arrived, R1 verbalized he was willing to be transported to a local hospital for evaluation and additional treatment. EMS left with R1 at approximately 03:20 - 03:25 PM. R1's physician was notified at approximately 03:30 PM.On 06/26/25 at 06:16 PM, staff documented R1's representative was notified by telephone at 06:00 PM and left a message when R1's representative did not answer the telephone.On 06/26/25 at 09:15 PM, staff documented R1 had an unplanned transfer to a hospital on [DATE] at 03:25 PM due to behavioral symptoms that included agitation and psychosis.On 06/26/25 at 09:24 PM, staff documented the facility called the hospital to verify R1's status. Hospital staff revealed R1 was admitted to a medical floor.On 06/30/25 at 04:48 PM, staff documented Social Services Designee (SSD) X emailed R1's representative with an emergency notice of transfer/discharge. Staff documented R1's needs could no longer be met by the facility, and R1 presented a safety risk to other residents. Staff documented R1 had chosen to be discharged from the facility. SSD X notified hospital staff and provided information related to alternate locations that might accept R1.On 07/01/25 at 06:27 PM, staff documented SSD X called the significant other of R1's representative since R1's representative had not responded to the facility's message left on 06/30/25. The significant other of R1's representative verbalized understanding that the facility could no longer meet R1's needs.R1's EHR Resident Documents contained a scanned letter, dated 06/26/25, to discharge R1 to a hospital on [DATE]. The letter documented the reasons for the discharge were: the discharge was necessary as the resident's needs could no longer be met by the facility; the discharge was necessary due to a safety risk to other individuals at the facility; the resident had chosen to be discharged from the facility. The letter was signed by Administrative Staff A.R1's EHR, reviewed 04/16/25 to 07/01/25, did not contain physician documentation of specific services the facility was unable to provide to R1 or that R1 posed a risk to the (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	safety of the other residents of the facility.On 09/09/25, Administrative Staff A and Administrative Nurse D were unavailable for interview.During an interview on 09/09/25 at 02:25 PM, Administrative Staff B revealed R1's discharge was not planned. Prior to his discharge, R1 had been sent multiple times to a hospital for his behaviors and attempts at self-harm; however, the hospital would only medicate R1 and discharge him back to the facility when no behaviors or attempts at self-harm were observed. R1 had attempted self-harm with anything he could find, so staff had removed potentially harmful objects from his room and placed padding on the walls and floor to prevent him from banging his head against the walls and/or floor. The facility had even attempted to refer R1 to a facility with a special unit for individuals with Huntington's disease, but the receiving facility declined to take R1 due to his history of attempts at self-harm. On the date R1 was discharged , he had attempted to strangle himself by wrapping the power cord for the television and the cords for the window blinds around his neck; it took three staff members to pry his fingers away and remove the cords from around his neck. Law Enforcement Officers (LEO) and EMS were called, and R1 was transported to a different hospital for psychiatric help.During an interview on 09/09/25 at 03:05 PM, Administrative Staff B stated the facility expected to be cited for the discharge of R1. The facility had exhausted all known resources and understood that R1 could not remain at the facility due to ongoing safety concerns for staff and other residents.The facility's 11/01/16 Transfer & Discharge policy documented the facility would permit each resident to remain and not transfer or discharge the resident except in accordance with Federal and State laws. The facility could transfer a resident if the resident's welfare and needs could not be met by the facility, or the safety of other individuals was endangered due to the resident. If the basis of the transfer or discharge was due to the safety or welfare of others, physician documentation would support the transfer.