STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175168	A. Building B. Wing	06/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Excel Healthcare and Rehab Wichita	7101 E 21st Street North Wichita, KS 67206

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42966 The facility identified a census of 98 residents. The sample included three residents reviewed for misappropriation of property. Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 1 remained free from misappropriation of medications when two tablets of Percocet (narcotic pain medication) were unaccounted for and never found by the facility. This deficient practice had the risk of missed medications and further misappropriation of medications for R1. Findings included: - R1 admitted to the facility on [DATE]. R1's Electronic Medical Record (EMR) documented diagnoses of generalized muscle weakness and primary generalized osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain). The Admission Minimum Data Set (MDS) dated [DATE], documented R1 had a Brief Interview for Mental Status (BIMS) score of 14 which indicated intact cognition. R1 received scheduled pain medications and complained of occasional pain rated highest at eight out of 10 in the last five days of the assessment period. R1 received opioid medications. The Pain Care Area Assessment, dated 05/21/24, documented R1 required assistance with some activities of daily living (ADLs) and was working with therapy services. R1's Care Plan, dated 03/07/24, documented R1 had pain related to arthritis, impaired mobility, obesity, wound status, and muscle spasms. The plan directed staff to administer analgesia per orders; staff anticipated R1's need for pain relief and responded immediately to any complaint of pain; and notified the physician if interventions were unsuccessful. R1's EMR documented an order with a start date of 05/28/24 for oxycodone-acetaminophen (Percocet) 7.5 milligrams (mg)- 325 mg one tablet three times a day for chronic pain and an order with a start date of 05/28/24 for oxycodone-acetaminophen 7.5 mg-325 mg one tablet as needed (PRN) for pain. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175168	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/24/2024

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a notarized Witness Statement on 06/14/24, CMA R stated on 06/12/24 around 09:45 PM, she and LN G counted the narcotics, and the count was off by one. She stated she looked at the narcotic count sheet and saw she signed the medication off for the pill but assumed she did not pop it out. CMA R stated LN G told her to pop it out and give it to R1, so she did that before she left. She stated the count was correct around 10:15 PM after counting three times. In a notarized Witness Statement on 06/14/24, LN G stated she worked on 06/12/24 from 06:00 PM to 06:00 AM and she counted with CMA R. She stated when they got to R1's Percocet, there was a difference of one pill and she alerted CMA R. LN G stated CMA R said she signed it but may have forgotten to pop it and give it to R1 so CMA R popped it in LN G's presence and gave it to R1. LN G stated, the next morning, when the CMA came in and counted with her, they were short two pills. She stated she realized when she counted with CMA R, she was short by one pill and CMA R popping another pill made it short by two pills. LN G stated she notified Administrative Nurse D who then told her he would investigate. The facility's investigation, dated 06/21/24, documented one medication cart on the East wing was found to be short two Percocet tablets at shift change on the morning of 06/13/24. The count appeared off at 10:00 PM on 06/12/24 and Certified Medication Aide (CMA) R and Licensed Nurse (LN) G thought they corrected the one pill error by administering another Percocet. After recounting, LN G accepted the medication cart. At the end of the shift on the morning of 06/13/24, the medication cart was found to be short of Percocet tablets. CMA R and LN G were suspended pending investigation and the incident was immediately reported to Administrative Nurse D and Administrative Staff A. CMA R and LN G were drug screened and tested negative for opiates. The pharmacy was contacted to order a replacement for the two tabs of Percocet. The facility found no substantiated theft. The investigation included a copy of the narcotic count sheet for R1's oxycodone/acetaminophen 7.5 mg-325 mg tablets documented on 06/12/24 at 07:27 PM, 138 tablets were remaining. The investigation included copies of R1's three medication cards of oxycodone/acetaminophen 7. 5 mg-325 mg tablets. Card one had 18 tablets, card two had 60 tablets, and card three had 58 tablets for a total of 136 tablets of oxycodone/acetaminophen. Upon request, the facility was unable to provide an invoice or receipt to verify the facility had replaced R1's missing Percocet tabs. On 06/24/24 at 02:57 PM, R1 lay in bed with her eyes closed. On 06/24/24 at 02:44 PM, Administrative Staff A stated the facility requested two replacement Percocet pills for R1 and the pharmacy sent a whole card and had not billed the facility. She stated she would reach out to the pharmacy to find out how the pharmacy could charge the facility for the missing pills. On 06/24/24 at 03:57 PM, CMA S stated she prevented discrepancies with narcotics by looking at the count sheet, how many pills were left, and who signed the last dose out. She stated she signed the narcotic count sheet when she popped a pill out. CMA S stated if there was a discrepancy, she notified the unit manager. She stated each new card has its narcotic count sheet now but only the nurses filled the sheets out when the medication came in. (continued on next page)

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/24/24 at 04:15 PM, LN H stated if she gave a narcotic, she verified in the count sheet before and after administering the medication. She stated she signed off the narcotic on the count sheet as she gave the medication and any discrepancies were reported to the nurse manager. On 06/24/24 at 04:35 PM, Administrative Nurse D stated the facility redid the narcotic count books because they were doing all of the narcotic cards on one page but now it is one page per narcotic card. He stated when staff came onto shift, one person stood over the narcotic book and one person stood by the cards. One person counted the medications while the other stated the medication and count number and the first person acknowledged the count. He stated when staff popped out a narcotic medication, they reviewed the order, signed the medication out in the narcotic count book then gave the medication. Administrative Nurse D stated the facility was unable to pinpoint a single person who took the two missing Percocet tablets. On 06/24/24 at 04:55 PM, Administrative Staff A stated it was difficult to substantiate misappropriation because they were unable to figure out where the Percocet tablets went. She stated the missing Percocet was initially treated as if it was a misappropriation until it was investigated but the facility could not substantiate it since they did not know who did it. She stated the facility also kind of treated it as a medication error to cover all of the bases. The facility's Controlled Substance Administration and Accountability policy, last revised February 2023, directed all controlled substances obtained from a non-automated medication cart or cabinet were recorded on the designated usage form and written documentation was legible with all applicable information provided. For areas without automated dispensing systems, two licensed nurses accounted for all controlled substances and access keys at the end of each shift. The facility's Abuse, Neglect, and Exploitation policy, revised February 2023, directed the facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibited and prevented abuse, neglect, exploitation, and misappropriation of resident property. The facility failed to ensure R1 remained free from misappropriation of medications when two tablets of Percocet were unaccounted for and never found by the facility. This deficient practice had the risk of missed medications and further misappropriation of medications for R1.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175168	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/24/2024
NAME OF PROVIDER OR SUPPLIER Excel Healthcare and Rehab Wichita		STREET ADDRESS, CITY, STATE, ZIP CODE 7101 E 21st Street North Wichita, KS 67206	

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42966 The facility identified a census of 98 residents. The sample included three residents reviewed for falls. Based on observation, record review, and interviews, the facility failed to implement interventions to prevent falls for Resident (R) 2, who was at risk for falls. This deficient practice had the risk of further falls/injuries and unwarranted physical complications for R2. Findings included: - R2's Electronic Medical Record (EMR) documented diagnoses of hemiplegia (paralysis of one side of the body) and hemiparesis (muscular weakness of one half of the body) following cerebral infarction (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) affecting left non-dominant side, abnormal posture, generalized muscle weakness, and dementia (progressive mental disorder characterized by failing memory, confusion) without behavioral disturbance. The Annual Minimum Data Set (MDS) dated [DATE], documented R2 had a Brief Interview for Mental Status (BIMS) score of two which indicated severe cognitive impairment. R2 had impairment on both sides of the upper and lower extremities and was dependent on staff for activities of daily living (ADLs). R2 had no falls since the last assessment. The Quarterly MDS dated [DATE], documented a BIMS was not completed due to R2 rarely/never understood. R2 had impairment on both sides of the upper and lower extremities and was dependent on staff for ADLs. R2 had no falls since the last assessment. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 11/29/23, documented R2 had major cognitive impairment with nonsensical communication. R2 was dependent and required assistance with all needs. R2's Care Plan revised 03/21/23, documented R2 was at risk for falls and had an actual fall related to altered mobility and dementia. The care plan documented an intervention, dated 01/31/20, that directed staff ensured R2's call light was within reach and encouraged R2 to use it for assistance as needed. The care plan documented interventions, revised 07/11/23, that directed R2's bed was placed in a low position, R2 had a perimeter mattress, R2 had a wide mattress, and staff may place mats around the scoop mattress for increased safety. R2's EMR revealed an Incident Note on 06/06/24 at 08:40 PM, that documented the CNA summoned the nurse to R2's room. The nurse entered R2's room and saw him lying face down on his abdomen on the floor to the right of his bed. The CNA stated they were giving R2 a bed bath and he rolled out of the bed and onto the floor when they rolled him over to wash his back. On 06/24/24 at 02:59 PM, R2 lay in bed with eyes open. R2 had a perimeter mattress on his wide mattress. R2's bed was not in the lowest position; R2's call light was hanging on a dispenser on the wall, out of R2's reach; and there were no fall mats observed on the floor. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/24/24 at 04:23 PM, Certified Nurse Aide (CNA) M stated staff knew what residents were at risk for falls from the care plan and in reports. She stated the care plan documented interventions to prevent falls which included the call light within reach and the bed in the lowest position for the least impact to the floor. On 06/24/24 at 04:27 PM, Licensed Nurse (LN) I stated staff knew what residents were at risk for falls from the Kardex (a nursing tool that gives a brief overview of the care needs of each resident) and staff checked the Kardex. She stated the Kardex had interventions to prevent falls and if there was a new intervention, it popped up on the EMR dashboard. LN I stated staff placed the call light within reach and the bed in the lowest position before leaving the room. On 06/24/24 at 04:35 PM, Administrative Nurse D stated he expected staff to prevent falls by rounding every two hours. He stated staff had access to the Kardex which had interventions for falls. Administrative Nurse D stated if there were fall interventions on the care plan, he expected staff to put the interventions in place before they left the resident's room. He stated bed was left in the lowest position unless care planned otherwise, and the call light was left within reach. The facility's Fall Prevention Program, dated 2023, directed the facility to implement environmental interventions that decreased the risk of a resident falling including, but not limited to a clear pathway to the bathroom and bedroom doors, bed locked and lowered to a level that allowed resident's feet to be flat on the floor when the resident was sitting on the edge of the bed, call light and frequently used items were within reach, adequate lighting, and wheelchairs and assistive devices were in good repair. The facility failed to implement interventions to prevent falls for R2, who was at risk for falls. This deficient practice had the risk of further falls/injuries and unwarranted physical complications for R2.