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 02/11/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 46960 The facility reported a census of 102 residents with 21 residents sampled. Based on interview, observation, and record review the facility failed to protect the dignity of Resident (R) 80 and R27 when the staff failed to remove unwanted facial hair and/or trim resident fingernails as needed. The facility further failed to ensure staff knocked before entering resident rooms and blinds were closed to the outside when performing resident care activities. These practices had the potential to lead to negative psychosocial effects related to dignity. Findings included: - An observation on 01/30/25 at 01:14 PM, R80 sat in his wheelchair with visitor present and visible facial hair over one inch long present on R80's face. During the obsesrvation an unknown staff member walked into R80's room without knocking or announcing themself. When the staff member was greeted by R80, the staff member turned around and walked out of the room. During an interview on 01/30/25 at 01:14 PM, R80 revealed he preferred to be clean shaven and stated staff had not assisted him. R80 stated the presence of his beard bothered him. R80 further revealed staff members frequently walked in his room without knocking or announcing themselves. During an observation on 01/30/25 at 01:53 PM, R27 rested in her bed with visible facial hair covering approximately two inches of her chin. Additionally, R27's fingernails were approximately two inches long on all fingers. During an interview on 01/30/25 at 01:53 PM, R27 reported she was ashamed of her long facial hair and fingernails and reported staff would not assist her with facial hair removal or clipping of fingernails. During an observation on 02/04/25 at 09:56 AM, R27 rested in her bed with visible facial hair covering approximately two inches of her chin. Additionally, R27's fingernails were approximately two inches long on all fingers. During an interview on 02/10/25 at 02:25 PM, R27 reported that the unwanted facial hair was removed on 02/09/25 by an unidentified staff member, but the staff member refused to cut her fingernails. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 02/10/25 at 03:09 PM, Certified Nurse Aide (CNA) SS and CNA TT performed incontinence care on R80 and failed to close the window blinds to the exterior of the building which had a public sidewalk approximately 25 feet from the building with public parking lot immediately beyond the sidewalk. During an interview on 02/10/25 at 04:10 PM CNA SS confirmed blinds in resident rooms should be closed during incontinence care. During an interview on 02/11/25 at 09:22 AM, Administrative Staff A stated nail care should be offered twice a month and removal of unwanted facial hair should be performed with shower/bathing. Administrative Staff A further confirmed residents had filed grievances with the facility related to lack of nail care. The facility did not provide a policy related to protecting residents' dignity as requested on 02/11/24 at 03:00 PM. The facility failed to protect the dignity of Resident (R) 80 and R27 when the staff failed to remove unwanted facial hair and/or trim resident fingernails as needed. The facility further failed to ensure staff knocked before entering resident rooms and blinds were closed to the outside when performing resident care activities. These practices had the potential to lead to negative psychosocial effects related to dignity.

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36881 The facility reported a census of 102 residents with 21sampled, which included three residents reviewed for choices. Based on observation, interview, and record review, the facility failed to provide choices for dependent Resident (R) 82 related to her preferences for type and frequency of bath/shower. Findings included: - Review of the Resident (R)82's, Physician Orders, dated 05/18/22, revealed diagnoses which included anxiety disorder, muscle weakness, reduced mobility, obesity (severe overweight), and need for assistance with personal care. The Annual Minimum Data Set (MDS) dated [DATE], documentation included her Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. She reported it was very important to choose what clothes to wear and type of bath. The resident was partial to moderate dependent on staff for assistance with bathing and dressing. The Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 01/06/25 documentation included the resident remained in the facility for assistance with cares. The resident was incontinent of bladder and required staff assistance with toileting and bathing/hygiene. The Care Plan (CP) dated 12/03/24, lacked indication of the residents bathing preference for frequency and desired type of bath. The CP directed staff to allow the resident to make decisions about her treatment regimen to provide her with a sense of control, initiated 07/36/23. The resident had a self-performance activities of daily living (ADLs) deficit due related to weakness, obesity, impaired mobility, and pain initiated 11/24/24. Review of R82's Bath Sheets for 01/14/25 through 02/08/24 (25 days) revealed the facility staff offered the resident opportunities for baths on five occasions, which included the resident received her preferred type of bath, (a shower) on one occasion on 01/28/25. Three of the five occasions bed baths were offered, of which two were not given due to no hot water on 01/21/25 and 01/25/25. On 02/03/25 at 11:25 AM Certified Nurse Aide (CNA) UU assisted the resident with a transfer from the toilet to her wheelchair with the use of a gait belt, verbal cues, and physical guidance. The resident reported the facility was out of hot water for three weeks. The first two weeks the facility staff did not offer alternate bathing methods in the place of her preferred morning shower. She stated after a couple of weeks the facility offered her a bath with wipes and reported she did not feel clean doing that. She stated she felt dirty which mad her crabby. R82 stated the regular staff would wash her bottom with wipes, but they did not have hot water. R 82 stated she had reported her concerns to the administrator and the administrator told her last month they were working on the problems, and to give it time, but things did not get any better. R82 revealed staff had not followed up on the resident's grievances. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/10/25 at 12:34 PM, Licensed Nurse (LN) H reported the facility was without water and the staff had not bathed residents in accordance with their preferences due to water temperatures when her water was turned on. He stated the staff should document on the bath sheets, including a skin assessment, when giving a bath and if the resident refused an offered bath or shower staff would notify the nurse of any bath refusals. On 02/11/25 at 09:48 AM Administrative Nurse F, stated the staff interviewed residents on admission regarding their preferences, which included preferred bathing type and frequency. She stated R82's bathing preference was for a shower before breakfast, four days a week on Sunday, Tuesday, Thursday, and Saturday. Upon review of the resident's medical record Administrative Nurse F verified R82's care plan lacked her preferences for type and frequency of bath. Additionally, the staff did not offer a bathing option four times a week as noted above. Administrative Nurse F reported the facility had difficulty with a maintenance issue related to the hot water boiler, which the facility had been working on repairs with an outside contractor. During the time the system was malfunctioning (01/14/25 through 02/11/25) the facility staff were to provide the residents with alternate methods of bathing to include bath wipes and heating the water in the kitchen. She verified the findings as noted above. The facility Policy Bed bath, dated 03/2021, lacked direction regarding indication of the resident's bathing preferences for frequency and type of bathing. The facility failed to provide choices for a dependent Resident 82 related to bathing preferences for four showers weekly or alternatives when hot water was not available.

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. 46960 The facility identified a census of 102 residents, which included 57 residents with active trusts held by the facility. Based on observations, interviews, and record review, the facility failed to provide quarterly statements for the 57 residents with trust accounts in the facility. Findings included: - Review of Trust Transaction History of all 57 residents who had active trusts held by the facility revealed no quarterly statements available for review. During an interview on 02/11/25 at 10:19 AM Administrative Staff PP revealed the facility maintained trust funds for 57 residents in the facility. Administrative Staff PP revealed quarterly statements were printed out and hand delivered to residents that had high cognitive functioning or mailed to the residents' representatives if the resident had low cognitive functioning. The facility was unable to provide documentation, which indicated quarterly statements were given to the 57 residents of the facility. The facility did not provide a policy related to management of trust funds. The facility failed to provide quarterly statements of each resident's personal funds entrusted to the facility on the resident's behalf.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 41302 The facility reported a census of 102 residents. The sample included 21 residents. Based on interview and record review the facility failed to ensure the correct and complete Beneficiary Protection Notification Forms were issued to one of three residents reviewed, Resident (R)56. Findings included: - On 02/10/25 review of the Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage Form CMS-10055 (SNF ABN) revealed Resident (R) 56 lacked the SNFABN form. On 02/11/25 at 10:49 AM, Administrative Staff A confirmed the form should have been given as required. The facility's policy Medicare Advance Beneficiary and Medicare Non-Coverage Notices dated September 2024, documented residents were given a Skilled Nursing Facility Advance Beneficiary Notice (CMA form 10055) when termination- if the facility proposes to stop furnishing all extended care items or services to a beneficiary because it expects that Medicare will not continue to pay for the items or services that a physician has ordered, the SNF ABN is issued to the beneficiary before such extended care items or services are terminated. The facility failed to ensure the correct and complete Beneficiary Protection Notification forms (SNF ABN 10055) were issued to R56, as required.

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 41302 The facility reported a census of 102 residents. The sample included 21 residents. Based on interview and record review the facility failed to provide adequate supervision for Resident (R) 157 when a tourniquet was left on his arm from a blood draw on a Friday and not found until Monday, a total of 5 days. Findings included: - R157's Electronic Health Record (EHR) revealed a diagnoses transient ischemic attack (TIA- temporary episode of inadequate blood supply to the brain), sepsis (life threatening systemic reaction that develops due to infections which cause inflammation throughout the entire body), and lactic acidosis (excessive accumulation of lactic acid produced by the muscle cells with the breakdown of carbohydrates for energy). The Electronic Health Record (EHR) documented an order dated 01/10/25 for hyponatremia (less than normal concentration of sodium in the blood), hyperkalemia (greater than normal amount of potassium in the blood), and transaminitis (a liver enzyme in the blood) lab tests to be obtained. The Progress Notes documented the following: On 01/09/25 at 12:00 PM, provider noted labs from today were pending. On 01/13/25 at 11:05 AM, Licensed Nurse (LN) J noted was informed that a tourniquet was found on R157's right arm. LN J assessed R157's arm and found it to have a deep blue ring around the upper right arm and reddish discoloration going down the arm. R157 had a brace to his right hand and his skin was not excessively warm. The resident's provider was notified and the facility received new orders for a doppler to his right arm. Mobile radiology was notified. On 02/10/25 at 12:48 PM Licensed Nurse (LN) C revealed their lab vendor left a tourniquet on a resident's arm and did not collect all of the ordered labs. On 02/10/25 at 12:54 PM LN J revealed she completed the assessment on R157's arm, obtained the order for the doppler, and notified mobile radiology. On 02/11/25 at 12:29 PM, Administrative Staff A revealed R157 had lab drawn on a Friday and the tourniquet was found on R157's right arm the following Monday. She confirmed that her expectation would have been that the tourniquet on the resident's arm be found much sooner. The facility's policy Abuse, Neglect, Exploitation, and Misappropriation Prevention Program dated 04/2021 documented residents have the right to be free from abuse, neglect, misappropriation of property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical and chemical restraint not required to treat the resident's symptoms. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The facility failed to provide a safe and secure living environment for the residents of the facility by the failure to provide adequate supervision to prevent Resident (R)157 from having a tourniquet left tightly on his arm for five days.

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F 0656

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 41302

The facility identified a census of 102 residents, which included 21 residents sampled and reviewed for care plan development. Based on interview, observations, and record review, the facility failed to develop a comprehensive person-centered care plan for four residents. Resident (R) 88, R75, and R82's comprehensive person-centered care plans did not contain resident's preferences for days and/or types of bathing. R14's comprehensive person-centered care plan did not have the tube feeding on his care plan. This deficient practice had the potential to lead to uncommunicated needs, which could lead to negative impacts on the resident's physical, mental and psychosocial well-being.

Findings included:

- Resident (R)88's Electronic Health Record (EHR) revealed diagnoses of edema (swelling resulting from an excessive accumulation of fluid in the body tissues), pain, and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).

The Annual Minimum Data Set (MDS) dated [DATE], documented a Brief Interview of Mental Status (BIMS) score of 11, which indicated moderately impaired cognition. The assessment documented R88 was continent of bowel and occasionally incontinent of bladder and required substantial/maximal assistance with ADL's (activities of daily living such as grooming, shower, footwear). Also, that it was very important to choose between bed bath, shower, and tub bath.

The Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 01/01/25, documented R88 required substantial/maximal assistance with shower/bathes.

The Care Plan dated 01/14/25, documented R88 required staff assistance for shower/bathing. The care plan lacked any documentation regarding R88's preference on times, days, or type of bathing.

Observation on 02/04/25 05:41 AM, revealed R88 lying in her bed in her room with no signs of distress noted.

During an interview on 02/11/24 at 02:46 PM, Licensed Nurse (LN) G revealed the floor nurses could add to, change, and start care plans. She stated she would expect their preferences to be on the care plan and available to their caregivers.

During an interview on 12/11/24 at 03:31 PM, Administrative Nurse F revealed that the nurse was expected to update care plans as needed. Confirmed that the resident's preferences should be on the care plan.

The facility's policy Care Plans, Comprehensive Person-Centered dated 03/2022 documented each resident's comprehensive person-entered care plan is consistent with the resident's rights to participate in the development and implementation of his or her plan of care, including the right to participate in the planning process, identify individuals or roles to be included, request meetings, request revisions to the plan of care, participate in establishing the expected goals and outcomes of care, participate in determining the type, amount, frequency, and duration of care.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility failed to develop a comprehensive person-centered care plan for R88 to include preferences of bathing time and type. -Resident (R)75's Electronic Health Record (EHR) revealed diagnoses of Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear). The Admission Minimum Data Set (MDS) dated [DATE], documented a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The assessment documented R75 was frequently incontinent of bowel and occasionally incontinent of bladder and required partial/moderate assistance with ADL's (activities of daily living such as grooming, shower, footwear). Also, that it was very important to choose between bed bath, shower, and tub bath. The Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 01/01/25, documented R75 required assistance with shower/bathes. The Care Plan dated 10/14/24, documented R75 required staff assistance for shower/bathing. The care plan lacked any indication of R75's preference on times, days, or type of bathing. Observation on 02/04/25 05:41 AM, revealed R75 lying in her bed in his room with no signs of distress noted. During an interview on 02/11/24 at 02:46 PM, Licensed Nurse (LN) G revealed the floor nurses could add to, change, and start care plans. She stated she would expect their preferences to be on the care plan and available to their caregivers. During an interview on 12/11/24 at 03:31 PM, Administrative Nurse F revealed that the nurse was expected to update care plans as needed. Confirmed that the resident's preferences should be on the care plan. The facility's policy Care Plans, Comprehensive Person-Centered dated 03/2022 documented each resident's comprehensive person-entered care plan is consistent with the resident's rights to participate in the development and implementation of his or her plan of care, including the right to participate in the planning process, identify individuals or roles to be included, request meetings, request revisions to the plan of care, participate in establishing the expected goals and outcomes of care, participate in determining the type, amount, frequency, and duration of care. The facility failed to develop a comprehensive person-centered care plan for R75 to include preferences of bathing time and type. 36881 - Review of the Resident (R)82's, Physician Orders, dated 05/18/22, revealed diagnoses which included anxiety disorder, muscle weakness, reduced mobility, obesity (severe overweight), and need for assistance with personal care. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Annual Minimum Data Set (MDS) dated [DATE], documentation included her Brief Interview for Mental Status (BIMS) score of 15, which indicated cognitively intact. She reported it was very important to choose what clothes to wear and type of bath. The resident was dependent on staff for partial to moderate for assistance with bathing and dressing. The Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 01/06/25 documentation included the resident remained in the facility for assistance with cares. Resident has diagnosis included heart failure, major depressive disorder, respiratory failure, chronic kidney diseases, morbid obesity, chronic obstructive pulmonary disease (COPD-), and hypertension (high blood pressure). The resident was incontinent of bladder and required staff assistance with toileting and bathing/hygiene. The Care Plan (CP), dated 12/3/24, lacked address of residents bathing preference for frequency and desired type of bath. On 02/10/25 at 12:34 PM, Licensed Nurse (LN) H He stated he did not know if the resident's care plan addressed her bathing preferences, but they should be in the care plan. On 02/11/25 at 09:48 AM, Administrative Nurse F, stated the staff interviewed residents on admission regarding their preferences which included bathing type and frequency all residents mid-January regarding their bathing preferences an updated the residents care plans. She stated R 82's bathing preference was for a shower before breakfast, four days a week on Sunday, Tuesday, Thursday, and Saturday. Upon review of the resident's medical record Administrative Nurse F verified R 82's care plan lacked her preferences for type and frequency of bath. The facility lacked a policy to address the development of a care plan related to the resident's preferences for type of bathing and/or frequency of bath. The facility failed to develop and implement a plan of care for dependent Resident (R)82 related to her preferences for type and frequency of bath/shower. 50659 - Review of R14's diagnoses from the Electronic Health Record (EHR) documented, anorexia (lack or loss of appetite), metabolic encephalopathy (condition in which brain function is disturbed either temporarily or permanently due to different diseases or toxins in the body), and dementia (progressive mental disorder characterized by failing memory, confusion). The 11/27/24 Quarterly Minimum Data Set (MDS) documented a BIMS score of two, which indicated severely impaired cognition. R14 required set up for eating and no weight loss noted. The 01/26/25 Significant Change (MDS) documented a Brief Interview for Mental Status (BIMS) score of one, which indicated severely impaired cognition. R14 required total staff assistance with activities of daily living (ADL). The MDS indicated R14 received tube feedings and had an unplanned weight loss of five percent (%) or more in the last month or a loss of 10% or more in the last six months. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 02/04/25 Nutritional Status Care Area Assessment (CAA) documented R14 readmitted from the hospital for a diagnosis of metabolic encephalopathy. R14 was noted to have dysphagia (swallowing difficulty) and moderate malnutrition. Due to R14's diagnosis, interventions included to monitor R14's weights per protocol, observe for chewing or swallowing problems, provide the diet and consistency per provider orders, and nothing by mouth (NPO a medical abbreviation used to indicate that a patient should not consume any food, liquids, or medications orally). The CAA also noted to refer R14 to speech therapy for a speech/swallowing evaluation. The 02/03/25 Care Plan lacked documented interventions for tube feeding for R14. The Physicians Orders dated 01/30/25 documented: 01/20/25 - Speech therapy evaluation and treatment as indicated 01/21/25 - NPO diet. 01/24/25 - Provide Glucerna 1.5 Cal (brand name of a family of tube feeding formula that was a calorically dense formula with specialized blend of low glycemic {release glucose slowly into the bloodstream, resulting in a gradual and moderate rise in blood sugar} and slowly digestible carbohydrates), administer one carton every four hours and flush with 30 milliliters of water after each feeding. The 01/202/25 at 05:41 PM, Progress Note revealed R14 was readmitted to facility from the hospital. The 01/21/25 (unknown time) Provider Progress Note revealed the provider assessed R14 and adjusted R14 to NPO at that time, until evaluated by speech therapy in the facility. The 01/23/25 at 09:38 AM Dietary Progress Note revealed Consultant Staff JJ (Registered Dietician) received consult for tube feeding. R14's current body weight was 137.2 lbs., indicating underweight, with an ideal body weight of 148 lbs. The recommended tube feeding order included Glucerna 1.5 Cal, one carton every four hours, with a goal of gradual weight gain to R14's ideal body weight. The staff were to monitor tube feeding tolerance, residuals, and weights. During an observation on 01/30/25 at 01:20 PM, noted sign in R14's room which read NPO. During an observation on 02/10/25 at 09:10 AM, R14 was in his bed on his back with the head of bed elevated. R14 put his hand up to his mouth as if he was holding a utensil, when R14 was asked with a note written do you want to eat food R14 shook his head yes. R14 used a white board to communicate with staff as he was deaf. During an interview on 02/04/25 at 02:04 PM, Certified Nurse Aide (CNA) O reported R14 would ask her for something to eat, and she knew he could no longer eat as he had a feeding tube. CNA O reported she would locate the information on the resident's care plan to know what care to provide. (continued on next page)

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 02/11/2025

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/10/25 at 12:51 PM, Administrative Nurse E reported that R14 did not have the care plan updated for his tube feeding interventions when he was readmitted on [DATE], until 02/04/25 (16 days later from admission). Administrative Nurse E reported the care plan should have been updated by the admission nurse to reflect the changes so staff would know what care was needed to be provided to R14. During an interview on 02/10/25 at 03:50 PM, Administrative Nurse D reported that R14's CP had been updated for his tube feeding and that the facility had 21 days to complete a comprehensive care plan. When the care plan was reviewed with Administrative Nurse D and Consultant Nurse KK, the care plan had routine visual checks after bolus tube feeding, date initiated 01/12/24 and revised on 02/04/2025 was observed. Furthermore, surveyor questioned the date initiated 01/12/24 date as R14 did not have a feeding tube until 01/20/25 when he returned from hospital. Nurse Consultant KK reported it must have been a clerical error when entered. Nurse Consultant KK opened the history button on the care plan in EHR which showed only revision dates of 02/02/25 and 02/04/25 for nutrition, no revised date noted for 01/2025. Administrative Nurse D reported that she expected the charge nurse would update the care plan in a timely manner for new interventions as needed. However, Administrative Nurse D could not state what a timely manner was. During an interview on 02/11/24 at 02:46 PM, Licensed Nurse (LN) G revealed the floor nurses could add to, change, and start care plans. The facility's policy Care Plans, Comprehensive Person-Centered dated 03/2022 documented each resident's comprehensive person-entered care plan is consistent with the resident's rights to participate in the development and implementation of his or her plan of care. The interdisciplinary team would review and update care plans when a significant change occurred for residents. The facility failed to develop a comprehensive care plan for Resident (R)14's tube feeding and interventions.

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 02/11/2025
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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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 46960 The facility reported a census of 102 residents which included 21 residents sampled and seven reviewed for ADL (activities of daily living such as walking, grooming, toileting, dressing and eating) care. Based on observations, interviews and record reviews, the facility failed to provide baths and/or showers to six residents who were dependent on staff for ADL care, Resident (R) 27, R80, R79, R76, R88 and R82. These deficient practices led to a failure to ensure the necessary services required for good personal hygiene were provided to the residents in the facility. Findings included: - Review of Resident (R) 79's Electronic Health Record (EHR) bathing task list from 01/06/25 to 02/02/25 revealed the resident received bath on 01/06/25 and 02/02/25. Review of R80's EHR Bathing Task List from 01/05/25 to 02/03/25 revealed the resident received baths on 01/06/25, 01/09/25, 01/11/25, 01/12/25, 01/28/25 and 02/01/25 with a documented refusal of a bath on 02/02/25. Review of R27's EHR Bathing Task List from 01/05/25 to 02/03/25 revealed the resident received baths 01/06/25, 01/09/25 and 01/24/25. Review of R76's EHR Bathing Task List from 01/06/25 to 02/03/25 revealed the resident received baths on 01/06/25, 01/09/25 with a documented refusal on 02/02/25. Review of R88's EHR Bathing Task List from 01/08/25 to 02/04/25 documented five showers during the look-back period. Review of R82's EHR Bathing Task List from 01/08/25 to 02/08/25 documented a bed bath on 01/21/25, a shower on 01/28/25, a bed bath on 02/01/25 and a bed bath on 02/08/25. During an interview on 02/11/25 at 10:37 AM, Certified Nurse Aide (CNA) R revealed baths and/or showers had not been given due to hot water being unavailable in the facility. During an interview on 02/11/25 at 10:45 AM, Licensed Nurse (LN) G revealed that baths and/or showers had not been given due to hot water being unavailable in the facility. During an interview on 02/11/25 at 10:45 AM, Administrative Nurse F revealed residents should have been bathed with bath wipes instead of a bath and/or shower. Administrative Nurse F did not have bathing wipes available for review. During an interview on 02/11/25 at 12:55 PM, Administrative Staff A revealed her expectation is for staff to accomidate for the lack of hot water and to be able to provide baths, which included the kitchen heating pots of water to provide warm water. Additionally, Administrative Staff A revealed residents should be provided with the same level of care even with the lack of hot water and reported that all members of management are certified and/or licensed and can assist with cares and are on site between the hours of 05:30 AM and 08:00 PM. (continued on next page)

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	175168	A. Building B. Wing	02/11/2025

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Activities of Daily Living (ADL), Supporting policy, dated 03/2018 documented that residents would be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out ADLs. Residents who were unable to carry out the ADLs independently would receive the services necessary to maintain good personal hygiene in accordance with the plan of care and included appropriate support and assistance. The facility failed to provide baths and/or showers to six residents who were dependent on staff for ADL care, R27, R80, R79, R76, R88 and R82. These deficient practices led to a failure to ensure the necessary services required for good personal hygiene were provided to the residents in the facility. 41302 - Resident (R)88's Electronic Health Record (EHR) revealed diagnoses of edema (swelling resulting from an excessive accumulation of fluid in the body tissues), pain, and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear). The Annual Minimum Data Set (MDS) dated [DATE], documented a Brief Interview of Mental Status (BIMS) score of 11, which indicated moderately impaired cognition. The assessment documented R88 was continent of bowel and occasionally incontinent of bladder and required substantial/maximal assistance with ADL's (activities of daily living such as grooming, shower, footwear). The Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 01/01/25, documented R88 required substantial/maximal assistance with shower/bathes. The Care Plan dated 01/14/25, documented R88 required staff assistance for shower/bathing. Review of the Task Bathing dated 01/11/25 through 02/11/25 documented showers given five out of 10 opportunities with up to 11 days between: 01/16/25 at 12:14 PM shower given. 01/20/25 at 12:27 PM shower given. 01/26/25 at 11:40 AM shower given. 02/05/25 at 01:59 PM shower given. 02/08/25 at 10:02 AM shower given. Observation on 02/04/25 05:41 AM, revealed R88 lying in her bed in her room with no signs of distress noted. During an interview on 02/11/25 at 11:20 AM, Certified Nurse Aide (CNA) R revealed she had not given showers as there has been no hot water, they are out of the wipes they were using for bathing. CNA R confirmed they had been unable to give showers for several weeks due to water availability issues. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/11/25 at 02:46 PM, Licensed Nurse (LN) G revealed that she was unsure of showers at this time as it had been an issue for some time, she stated she did know they had gotten wipes to use instead of showers. During an interview on 02/11/24 at 10:45 AM, Administrative Nurse F revealed the facility had no hot water in the showers at this time, but that residents should be offered baths with ready bath wipes which already have soap on them, and they can be placed in the microwave to get them warm. Administrative Nurse F revealed the facility had no microwaveable wipes but had others that could be used without warming up. The facility's policy ADL (Activities of Daily Living) dated 03/2018 documented the facility staff would provide for residents who were unable to carry out ADL independently, with consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene bathing, dressing, grooming, and oral care. The facility failed to ensure R88, who was unable to carry out activities of daily living, received the necessary services to maintain good grooming and personal hygiene.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41302 The facility census totaled 102, with 21 residents in the sample. Based on observation, interview, and record review the facility failed to provide the necessary care for Resident (R) 88 related to obtaining ordered medications. Findings included: - Resident (R) 88's Electronic Health Record (EHR) revealed diagnoses of edema (swelling resulting from an excessive accumulation of fluid in the body tissues), pain, and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear). The Annual Minimum Data Set (MDS) dated [DATE], documented a Brief Interview of Mental Status (BIMS) score of 11, which indicated moderately impaired cognition. The assessment documented R88 was continent of bowel and occasionally incontinent of bladder and required substantial/maximal assistance with ADL's (activities of daily living such as grooming, shower, footwear). The Electronic Health Record (EHR) documented an order dated 12/09/24 for Replens external comfort vaginal gel (vaginal moisturizer) insert one application vaginally at bedtime every Tuesday, Thursday, and Saturday for vaginal dryness. The EHR Census log documented R88 was on paid hospital leave from 01/26/25 to 01/30/25. The Progress Notes Encounter documented on 12/08/24 at 11:00 PM, documented R88 did have itchiness to her labia and nursing reported she had been scratching the area frequently. Replens external comfort vaginal gel was ordered for vaginal dryness. The Progress Notes documented on 12/12/24 at 09:04 PM, documented R88's Replens external comfort vaginal gel was on order. The Progress Notes documented on 12/26/24 at 11:26 PM, documented R88's Replens external comfort vaginal gel was pending delivery. The Progress Notes documented on 01/04/25 at 09:04 PM, R88's Replens external comfort vaginal gel was unable to be located and that pharmacy was notified. The Progress Notes documented on 01/21/25 at 08:55 PM, documented R88's Replens external comfort vaginal gel was pending delivery. The Progress Notes Encounter documented on 01/30/25 at 11:00 PM, documented R88 presented to the hospital on 01/26/25 with vaginal itching and was found to have candidiasis, returned from the hospital with miconazole cream. The Electronic Health Record (EHR) documented an order dated 01/30/25 for Replens external comfort vaginal gel (vaginal moisturizer) insert one application vaginally at bedtime every Tuesday, Thursday, and Saturday for vaginal dryness. (continued on next page)

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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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 02/04/25 05:41 AM, revealed R88 lying in her bed in her room with no signs of distress noted. During an interview on 02/11/25 at 11:58 AM, Licensed Nurse G stated that the night shift would administer the Replens gel. LN G searched the treatment cart and could not find the gel. LN G stated she would order from the pharmacy. During an interview on 02/11/25 at 01:06 PM, Consultant MM reported that the pharmacy had not delivered Replens external comfort vaginal gel until this date. That the applicators delivered would last two and a half weeks and could, if the facility requested, be put on automatic refill. The facility failed to provide a policy as requested on 02/11/25. The facility failed to provide the necessary care for R88 related to obtaining ordered medications.

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50659 The facility identified a census of 102 residents with 21 sampled, which included one resident reviewed for pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction). Based on observation, interview, and record review the facility failed to implement care plan interventions to prevent the development of facility-acquired, stage 3 pressure ulcers/injuries (full thickness pressure injury extending through the skin into the tissue below) for Resident (R)14. Findings include: - Review of R14's diagnoses from the Electronic Health Record (EHR) documented: anorexia (lack or loss of appetite), metabolic encephalopathy (condition in which brain function is disturbed either temporarily or permanently due to different diseases or toxins in the body), and dementia (progressive mental disorder characterized by failing memory, confusion). The 11/27/24 Quarterly MDS documented a BIMS score of two, which indicated severely impaired cognition. R14 required set up assistance from staff for eating, supervision of staff for bed mobility, and he was independent with transfers. The MDS noted R14 had no pressure ulcer injuries or skin concerns. The 01/26/25 Significant Change Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of one, which indicated severely impaired cognition. R14 required total staff assistance with activities of daily living (ADLs) including toileting hygiene, bathing, dressing, bed mobility, and transfers. R14 was incontinent of bladder and bowel frequently. The MDS indicated R14 received tube feedings and had an unplanned weight loss of five percent (%) or more in the last month or loss of 10% or more in last 6 months. R14 was at risk for pressure ulcers and had no pressure ulcer/injuries or skin concerns noted on the assessment. The 02/04/25 Pressure Ulcer/Injury Care Area Assessment (CAA) documented R14 readmitted from the hospital with a diagnosis of metabolic encephalopathy. R14 was noted to have dysphagia (swallowing difficulty) and moderate malnutrition. Interventions would include to apply moisturizer to his skin as needed, not massaging over bony prominences, and the use of mild cleansers for care. The staff would provide frequent incontinent care and prompt removal of wet/damp clothing or sheets as need and provide the resident with pressure relieving devices. The 02/03/25 Care Plan documented interventions initiated 08/04/21 and revised 02/24/23, as follows: Staff were instructed to apply moisturizer to R14's skin as needed, instructed not to massage over bony prominences, and use mild cleansers for peri care/washing. Staff were instructed to minimize extended exposure of the resident's skin to moisture by providing frequent incontinence care and prompt removal of wet/damp clothing or sheets as needed. (continued on next page)

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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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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Staff were instructed to monitor, document, and report to the provider changes in R14's skin status. Staff were instructed to provide a pressure relieving/reducing device on the resident's bed and wheelchair. The Physicians Orders dated 02/03/25 documented the following: 01/20/25 - May have Wound nurse consult; Complete Braden Score (pressure ulcer score) weekly times four. 01/21/25 - Complete a weekly skin evaluation every Saturday during evening shift. 01/31/25 - Wound care to the right and left medial (towards the middle) buttocks. Staff were to cleanse open areas to both of R14's inner buttocks with normal saline (NS- saline water solution for medical use), apply Xeroform (sterile non-adhering fine mesh gauze treated with a bacteriostatic agent) to wound bed, cover with Calcium Alginate (a highly absorbent wound dressing made from seaweed) and secure the area with a foam boarder for full thickness skin loss on each medial buttock. The dressing would be changed every Monday, Wednesday, Friday, and as needed if soiled, saturated, or missing. The 01/20/25 at 05:41 PM Readmission Evaluation documented R14 had bruises and identified R14's coccyx had areas of friction present. Administrative Nurse D informed LN I (wound nurse) of the findings and pictures of the areas were taken. The evaluation further noted R14 had incontinence of bowel movement upon readmission to the facility and the Mepliex (absorbent, bordered foam dressing) on the resident's coccyx was removed. The 01/20/25 at 06:45 PM Skin/Wound Note documented a bruise on R14's left inner arm and left hand, from readmission. The 01/20/25 at 09:26 PM Braden Scale assessment documented R14 had a score of 17, which indicated the resident was at risk for skin breakdown. The 01/28/25 at 11:16 AM Skin Evaluation/Assessment documented no new skin concerns. The Progress Note dated 01/31/25 at 11:07 PM documented R14 had open areas to the right and left medial buttocks. Staff notified LN I (wound nurse) and the provider, with no new orders received. The 02/04/25 at 10:40 AM Skin/Wound Evaluation was not completed by LN I, who opened the evaluation, and it remained in progress on 02/11/25. Review of the EHR from 01/31/25 thru 02/11/25 lacked measurements of the open areas to the resident's buttocks. During an observation on 02/03/25 at 02:52 PM R14 was in his bed with the television on, and the head of bed elevated. R14 was positioned on his buttocks. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an observation on 02/04/25 at 05:07 AM R14 was in his bed low to floor, fall mat in place head of bed elevated, and he was positioned on his buttocks. During an observation on 02/04/25 at 07:27 AM, LN Y completed wound care on R14. Observation revealed three open areas on the resident's medical buttocks. One open area on left medial buttock had a red wound base that extended through all the skin layers. The two open areas on the right medial buttock had a deep, reddish crater that has extended through all skin layers. LN Y reported she would not measure the areas as the wound nurse measured the pressure ulcers. During an observation on 02/04/25 at 01:59 PM, the facility applied an air mattress to R14's bed by an outside vendor. The Physicians Orders dated 02/04/25 instructed staff to apply a low air loss mattress to the resident's bed for skin management and set it according to resident's weight. Staff were to check the setting and function every shift for mattress monitoring. During an observation on 02/10/25 at 12:15 PM R14 was in his bed low to floor, fall mat in place head of bed elevated, and he was positioned on his buttocks. During an interview on 02/10/25 at 12:49 PM Certified Nurse Aide (CNA) AA, observed exiting R14's room, reported she had provided incontinent care to R14 and left him on his back as he had no positioning pillows or devices in the room, and he had no repositioning on his care plan. CNA AA reported R14 had a dressing on his buttocks. During an interview on 02/03/25 at 11:52 AM, LN I wound nurse reported she could not call R14's Guardian/Conservator (is a person who manages the day-to-day life of another person, while a conservator is a person who manages the financial affairs of another person) as his old Guardian had been removed in 12/24 in the EHR. The court appointed a new guardian/conservator as the death of the original guardian occurred. LN I said a required consent was needed before the facility wound consultant company would assess R14's wounds. LN I reported the nurse who first assessed R14's wounds on 01/31/25 received an order and treatment from the provider. During an interview on 02/03/25 at 03:25 PM, LN I reported the camera was not working the day she looked at R14's wound, but another nurse may have taken a picture. LN I reported she wanted a wound protocol at the facility, and she was fairly new to this position. LN I reported R14 should be repositioned off of his back at least every two hours. LN I stated R14 should have an air mattress on the bed, and she was not sure why he did not have an air mattress but would look into that. LN I reported R14 had a Stage 3 pressure ulcer on each buttock and R14 did not have any skin breakdown when he readmitted to the facility on [DATE]. During an interview on 02/10/25 at 12:51 PM, Administrative Nurse E reported R14 should have had positioning devices in place to reposition R14 off his buttock and be repositioned by staff at least every two hours. (continued on next page)

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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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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 02/10/25 at 04:10 PM, Administrative Nurse D reported R14 developed a facility acquired pressure ulcer since his readmission on 01/20/25. Administrative Nurse D reported R14 should have had positioning devices in his room to use when staff repositioned him in bed. Administrative Nurse D reported staff were not to leave the resident on his back in bed and noted he should be turned side to side. Administrative Nurse D said R14 did not have an air mattress applied to his bed until the afternoon of 02/04/25, as the facility had to wait for an air mattress to be delivered. The facility's Pressure Ulcer/Skin Breakdown- Clinical Protocol dated 03/2014 documented the nursing staff and attending physician would assess and document on individuals significant risk factors for developing pressure ulcers, for example immobility, recent weight loss and history of pressure ulcers. The facility failed to implement interventions to prevent the development of three facility-acquired, stage 3 pressure injuries for R14. The facility further failed to regularly assess, monitor, and document R14's wounds after staff initially identified the resident's wounds had developed. These failures resulted in preventable wounds to R14's buttocks and placed him at an increased risk for further development of pressure injuries skin conditions.

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F 0689 Level of Harm - 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** 50659 The facility reported a census of 102 residents with 21 sampled. Based on observation, interview, and record review the facility failed to ensure staff assessed Resident (R) 409 after a fall on 01/27/25 and failed to document the fall and/or the resident's status after the fall until the resident transferred to a local hospital and was diagnosed with multiple fractures (broken bones). Findings included: - R409's Physician's Orders dated 01/09/25 revealed the resident had a diagnosis of unspecified fracture of the left femur (broken bone). The Admission Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview Mental Status (BIMS) score of 11 indicating moderately impaired cognition. The resident had no behaviors exhibited, required a wheelchair for mobility and required substantial/maximal assistance with all activities of daily living (ADL). The Care Area Assessment[s] dated 01/15/25 for Cognitive Loss/Dementia and Falls revealed R409 admitted from hospital after falling at home and sustaining a left femur (thigh bone) fracture and left clavicle (collarbone) fracture. The Care Plan revision dated 01/21/25 revealed R409 had a risk for falls related to confusion gait/balance problems, incontinence, weakness, and a recent fall with femur and clavicle fracture. The Care Plan intervention dated 01/21/25 revealed the resident required the use of anti-roll back brakes to the wheelchair, a fall mat beside the bed, frequent checks, and staff would monitor/document the resident's pain level. Staff would ensure the surgical incision to the resident's left femur had a dressing in place until she could be seen by the orthopedic physician. Review of the facility Investigation Notes dated 02/05/25 revealed on 01/27/25 at 04:30 PM a local hospital notified the charge nurse, Licensed Nurse (LN) J, R409 had a right-side fracture of the pelvis. The nurses' notes lacked any reports of the resident falling or any indication of pain since the last recorded incident on 01/16/25. Upon further investigation by the facility, R409's roommate reported R409 fell while attempting to stand from her unlocked wheelchair. Staff alerted the nurse of the fall, and she assessed R409, then all three of the staff members lifted the resident from the floor. The resident was transported to the nurse's station. The investigative note documented on 01/27/25 the facility attempted to contact the Licensed Nurse working on the shift when R409 fell to write a statement regarding the resident's record lacking a fall assessment or documentation the facility's fall protocol was followed. Observation on 02/03/25 at 02:54 PM revealed R409 was in her wheelchair with her left arm in a sling and no facial grimace or signs of pain noted. (continued on next page)

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 02/11/2025
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 - Actual harm Residents Affected - Few	Interview with Certified Nurse Aide (CNA) R on 02/10/25 at 11:25 AM revealed the resident was on fall precautions as she always tried to get up out of her bed. CNA R reported she heard the resident sustained a fracture of the pelvic area the last time she fell . Interview with CNA S on 02/11/25 at 12:50 PM revealed if a resident fell staff were to report it to the charge nurse, and not move the resident until an assessment was completed. During an interview on 02/10/25 at 02:20 PM Administrative Nurse D revealed she expected for all nurses to assess a resident with each fall, notify the provider, responsible party, and nurse manager. Administrative Nurse D stated she would re-educate any nurse who did not provide appropriate care to residents. The facility policy Fall and Fall Management dated March 2018 revealed facility staff will identify interventions related to resident's specific risk factors and causes to try to prevent the resident from falling and to try to minimize complications from the fall. The facility failed to assess R409 after a fall on 01/27/25. The facility further failed to document the fall and/or the resident's status after the fall until the resident transferred to a local hospital and was diagnosed with multiple fractures.

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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 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 50659 The facility identified a census of 102 residents, with 21 sampled, and one resident reviewed for weight loss. Based on observation, interview, and record review, the facility failed to monitor the weight loss and failed to develop care plan interventions to address the weight loss for cognitively impaired Resident (R) 14, who had an identified weight loss of 20.54% in one month. This deficient practice had the potential to negatively affect the resident's physical well-being. Findings include: - Review of R14's diagnoses from the Electronic Health Record (EHR) documented, anorexia (lack or loss of appetite), metabolic encephalopathy (condition in which brain function is disturbed either temporarily or permanently due to different diseases or toxins in the body), and dementia (progressive mental disorder characterized by failing memory, confusion). The 11/27/24 Quarterly Minimum Data Set (MDS) documented a BIMS score of two, which indicated severely impaired cognition. R14 required set up for eating and no weight loss noted. The 01/26/25 Significant Change (MDS) documented a Brief Interview for Mental Status (BIMS) score of one, which indicated severely impaired cognition. R14 required total staff assistance with activities of daily living (ADL). The MDS indicated R14 received tube feedings and had an unplanned weight loss of five percent (%) or more in the last month or a loss of 10% or more in the last six months . The 02/04/25 Nutritional Status Care Area Assessment (CAA) documented R14 readmitted from the hospital for a diagnosis of metabolic encephalopathy. R14 was noted to have dysphagia (swallowing difficulty) and moderate malnutrition. Due to R14's diagnosis, interventions included to monitor R14's weights per protocol, observe for chewing or swallowing problems, provide the diet and consistency per provider orders, and nothing by mouth (NPO a medical abbreviation used to indicate that a patient should not consume any food, liquids, or medications orally). The CAA also noted to refer R14 to speech therapy for a speech/swallowing evaluation. The 02/03/25 Care Plan documented interventions for R14 which included: 08/04/21 - Staff instructed to observe R14 for chewing or swallowing problems and to offer alternatives of comparative nutritional value. 10/14/21- Staff instructed to refer to speech therapy for a speech/swallowing evaluation. Staff were to provide the diet and consistency, per physician order - puree, double portion meat portions. 07/11/23 - Staff to provide Ensure plus once daily. 01/01/25 - Staff instructed to monitor R14's weights, per protocol. The Physicians Orders dated 01/30/25 documented: (continued on next page)

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F 0692

Level of Harm - Actual harm

Residents Affected - Few

01/20/25 - Speech therapy evaluation and treatment as indicated

01/21/25 - NPO diet.

01/21/25 - Administer Mirtazapine (antidepressant medication) tablet 7.5 milligram (mg), give 7.5 mg, via feeding tube at bedtime for appetite.

01/21/25 - Complete admission and weekly weight for four weeks.

01/24/25 - Provide Glucerna 1.5 Cal (brand name of a family of tube feeding formula that was a calorically dense formula with specialized blend of low glycemic {release glucose slowly into the bloodstream, resulting in a gradual and moderate rise in blood sugar} and slowly digestible carbohydrates), administer one carton every four hours and flush with 30 milliliters of water after each feeding.

Review of weights in the EHR from 06/17/24 until 02/07/25 documented the following weights for R14:

06/17/24 at 11:12 AM weighed 162.6 pounds (lbs.).

07/02/24 at 01:22 PM weighed 167.0 lbs.

08/08/24 at 08:06 AM weighed 162.2 lbs.

08/19/24 at 01:06 PM weighed 165.5 lbs.

09/03/24 at 01:29 PM weighed 160.6 lbs.

10/01/24 at 08:56 AM weighed 163.2 lbs.

12/17/24 at 04:59 PM weighed 167.0 lbs.

01/09/25 at 10:56 AM weighed 137.2 lbs.

01/20/25 at 08:27 PM weighed 137.2 lbs. (a 17.10% loss since 08/19/24 and a 20.54% loss since 12/17/24).

02/07/24 at 05:00 PM weighed 155.2 lbs. (18 days since the prior weight).

The 01/09/25 (unknown time) Provider Progress Note included the provider saw R14 and Administrative Nurse E reported the resident had a recent weight loss noted. It was reported R14 also had decreased intake/appetite overall, as well as increased weakness/fatigue and an overall change in condition. The provider ordered a Chest X-ray, labs, and Mirtazapine 7.5 mg tablet, give one tablet orally, at bedtime for appetite stimulant.

The 01/11/25 at 04:05 PM Progress Note revealed R14 looked different than what was normal for him. Vital signs included a blood pressure of 98 millimeters of Mercury (mmHg) systolic over 56 mmHg diastolic, and a pulse of 105 beats per minute. R14 refused oxygen monitoring, and his breathing was labored. The staff called the Physician and received an order to send R14 to the hospital .

(continued on next page)

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	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Excel Healthcare and Rehab Wichita	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 0692 Level of Harm - Actual harm Residents Affected - Few	The 01/202/25 at 05:41 PM, Progress Note revealed R14 was readmitted to facility from the hospital. The 01/21/25 (unknown time) Provider Progress Note revealed the provider assessed R14 and adjusted R14 to NPO at that time, until evaluated by speech therapy in the facility. The 01/23/25 at 09:38 AM Dietary Progress Note revealed Consultant Staff JJ (Registered Dietician) received consult for tube feeding. R14's current body weight was 137.2 lbs., indicating underweight, with an ideal body weight of 148 lbs. The recommended tube feeding order included Glucerna 1.5 Cal, one carton every four hours, with a goal of gradual weight gain to R14's ideal body weight. The staff were to monitor tube feeding tolerance, residuals, and weights. The 01/26/25 (unknown time) Provider Progress Note included Speech therapy planned to evaluate R14 today to determine if he was safe for PO intake . During a review on 02/11/25 of the EHR, lacked a documented speech evaluation. During an observation on 01/30/25 at 01:20 PM, noted sign in R14's room which read NPO. During an observation on 02/10/25 at 09:10 AM, R14 was in his bed on his back with the head of bed elevated. R14 put his hand up to his mouth as if he was holding a utensil, when R14 was asked with a note written do you want to eat food R14 shook his head yes. R14 used a white board to communicate with staff as he was deaf. During an observation on 02/10/25 at 03:32 PM, R14 was observed by surveyor to have a weight completed by Certified Nurse Aide (CNA) R, CNA AA, and Administrative Nurse E. Staff utilized a mechanical lift scale which had been zeroed out. Weight revealed 141.0 pounds. During an interview on 01/30/25 at 01:20 PM, R14 reported he would eat food when he asked for the food. During an interview on 02/04/25 at 02:04 PM, Certified Nurse Aide (CNA) O reported R14 would ask her for something to eat, and she knew he could no longer eat. During an interview on 02/10/25 at 12:51 PM, Administrative Nurse E reported she had not witnessed the weight obtained on 02/07/25 for R14. Administrative Nurse E said CNA O reported the weight of 155.2 lbs. to her, and she documented that weight in the EHR. During an interview on 02/10/25 at 01:02 PM, Therapy Staff II (Director of Therapy) reported Therapy Staff LL (Speech Therapist) completed an evaluation for R14 and R14 had not started speech therapy. During an interview on 02/10/25 at 03:45 PM, Consultant Staff II reported she attempted to contact Consultant Staff LL, who completed R14's evaluation, as the evaluation could not be located. Consultant Staff II reported the speech evaluation was written on a piece of paper. (continued on next page)

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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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F 0692 Level of Harm - Actual harm Residents Affected - Few	During an interview on 02/11/25 at 01:17 PM, Consultant Staff LL reported she had completed a speech evaluation on R14 on 01/27/25 the last day she worked at the facility. Additionally, Consultant Staff LL reported she wrote the evaluation on a piece of paper, as she did not know to complete the evaluation in the EHR. Consultant Staff LL reported she texted Consultant Staff II the evaluation was completed, and she recommend R14 to start speech therapy. Consultant Staff LL reported she could not locate the locate the handwritten speech evaluation and reported that was a concern During an interview on 02/10/24 at 04:10 PM, Administrative Nurse D reported R14 had a speech evaluation completed and she did not know the evaluation could not be located. Administrative Nurse D stated it was reported by Consultant Staff II the evaluation was written on a piece of paper. Administrative Nurse D expected the evaluation to be completed and documented in the EHR. Administrative Nurse D expected R14 would have started speech therapy already. Administrative Nurse D reported she expected weights to be completed for all residents, per the physician orders. Administrative Nurse D confirmed R14 had a significant weight loss, and the weight loss was unacceptable. Administrative Nurse D confirmed the weight loss and tube feeding was not documented on the care plan in a timely manner. During an interview on 02/10/25 at 04:46 PM, Consultant Staff JJ (Registered Dietician) reported a virtual weight loss meeting occurred once a month with the interdisciplinary team (IDT) for weight loss that triggered for every single resident. Consultant Staff JJ confirmed R14 had a significant weight loss of 18% in one month and she had recommended weekly weights on 02/04/25. Consultant Staff JJ expected staff to obtain weights as ordered. She also reported the Speech Therapist had completed an evaluation for R14; however, she had not received a copy of the speech recommendations. The facility's undated policy Evaluation Therapy Plan of Care documented an evaluation by Speech-Language Pathologist required professional skills to make clinical judgement about conditions for which services were indicated based on objective measurement, and subjective evaluation of patient performance and abilities. Initiate the evaluation 24 hours after the order was obtained or next business day. The facility's policy Weight Assessment and Intervention dated 03/2022 documented resident's weights are monitored for undesirable or unintended weight loss or gain. Residents are weighed upon admission and intervals established by the IDT. Any weight change of 5% or more would be re-weighed the next day to confirm weight. If 5% weight change was confirmed the Registered Dietician would be notified in writing by nursing. One month weight loss of greater that 5% was severe. The facility failed to monitor weight loss and care plan weight loss interventions for cognitively impaired R14, who had a severe weight loss of 20.54% in one month. This deficient practice had the potential to negatively affect the resident's physical well-being.

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40801 The facility reported a census of 102 with 21 residents in the sample. Based on observations, interview and record review the facility failed to ensure competent nursing staff when the LN did not apply a pressure dressing to R5's ruptured and heavily bleeding hematoma (collection of blood trapped in the tissues of the skin or in an organ, resulting from trauma) on the resident's right lower leg. The facility failed to maintain the quality of care for R409 which included lack of assessment, documentation from a fall on 01/27/25 which caused a fracture (broken bone) of the pelvic area. Findings included: - The Physician's Orders dated 02/03/25 revealed R5 had a diagnosis of hemiplegia (muscle weakness of one half of the body) and hemiparesis (paralysis of one side of the body) following a cerebral infraction (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). The Significant Change Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of six, indicating severely impaired cognition. The MDS noted the resident was at risk for pressure ulcers and had no open lesions. The Quarterly MDS dated 11//13/24 revealed a BIMS score of three, indicating severely impaired cognition. The Care Plan revised on 02/02/25 revealed R5 had actual impairment to skin on the leg related to pressure, the facility staff are to follow the protocols regarding treatment of an injury. Monitor and document location, size and treatment of skin injury, report abnormalities, failure to heal sign and symptoms of infection. The Nurse's Notes revealed on 01/23/25 R5 observed to have acute swelling to right lower leg noted localized warmth and pain throughout the appearance could be due to cellulitis versus hematoma due to lump noted as well. Doppler order for venous and arterial which results indicated negative outcome. The Nurses Notes dated 01/26/25 at 12:40 PM revealed R5 had an with an open area to the right lower leg shin site the area was cleansed with normal saline and a pressure dressing applied. A nurse aide later noticed there was blood oozing out of wound site and running down R5's leg and foot. The nurses' notes dated 01/26/25 at 12:55 PM revealed an order received to send R5 to the emergency room for evaluation and treatment of bleeding of the right lower leg. The Investigation revealed on 02/10/25 at 09:30 AM the nurse on duty requested Licensed Nurse (LN) I to come to her unit to address R5's wound. The LN on the east side did not provide adequate nursing care she did not applying pressure to the wound on the resident's right lower leg but did obtain an order to send R5 to the emergency room . The facility removed LN from the schedule and terminated LN. (continued on next page)

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 02/04/25 at 10:40 AM revealed R5 in his bed watching television in a hospital gown on. R5's right leg had a wound vac (a vacuum assisted wound treatment that applies gentle suction to a wound to help it heal) in place. Observation on 02/10/25 at 03:50 PM revealed LN I provided wound care to R5. The wound sited measured approximately 13 centimeters (cm) in length by 9.3 cm in width by 0.6 cm in depth. The tissue was bright red in color, with no abnormal tissue noted, and the LN reapplied the wound vac. Interview on 02/11/25 at 09:20 AM with LN I revealed R5 had a hematoma, that started out as a blister, and it opened on 01/26/25 two days after the blisters formed. LN I said R5 had skin missing on the top part of both blisters and staff were cleaning the area with normal saline and putting a dressing over the area. On 01/26/25 the resident started having extreme bleeding and the nurse on his side of the facility did not apply pressure to the area or explain to LN I the bleeding was extreme. Interview on 02/10/25 at 09:45 AM with Administrative Nurse D revealed the nurse failed to provide appropriate care such as applying pressure or a pressure dressing to a bleeding wound the nurse voiced it was too much for her. The Pressure Ulcer and Skin breakdown revision date 02/2014 revealed treatment management the physician will authorize pertinent orders related to wound treatment including wound cleansing, dressing and applications of topical agents if indicated. The facility did not provide a policy on skin issues as requested on 02/11/25 The facility failed to ensure competent nursing staff when the licensed nurse did not apply a pressure dressing in response to R5's ruptured and heavily bleeding hematoma (collection of blood trapped in the tissues of the skin or in an organ, resulting from trauma). - R409's Physician's Orders dated 01/09/25 revealed the resident had a diagnosis of unspecified fracture of the left femur (broken bone). The Admission Minimum Data Set 9MDS) dated [DATE] revealed a Brief Interview Mental Status (BIMS) score of 11 indicating moderately impaired cognition. The resident had no behaviors exhibited, required a wheelchair for mobility and required substantial/maximal assistance with all activities of daily living (ADL). The Care Area Assessment[s] dated 01/15/25 for Cognitive Loss/Dementia, and Falls revealed R409 admitted from hospital after falling at home and sustaining a left femur (thigh bone) fracture and left clavicle (collarbone) fracture. The Care Plan revision dated 01/21/25 revealed R409 had a risk for falls related to confusion gait/balance problems, incontinence, weakness, and a recent fall with femur and clavicle fracture. The Care Plan intervention dated 01/21/25 revealed the resident required the use of anti-roll back brakes to the wheelchair, a fall mat beside the bed, frequent checks, and staff would monitor/document the resident's pain level. Staff would ensure the surgical incision to the resident's left femur had a dressing in place until she could be seen by the orthopedic physician. (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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Agency Nurse on 1/27/25 sent R 409 to the hospital for changes in mental status and complaints of pain and agitation the hospital notified the facility of the facture to the pelvic area the EMR lacked x-ray report from the hospital Review of the facility Investigation Notes dated 02/05/25 revealed on 01/27/25 at 04:30 PM a local hospital notified the charge nurse, Licensed Nurse (LN) J, R409 had a right-side fracture of the pelvis. The nurses' notes lacked any reports of the resident falling or any indication of pain since the last recorded incident on 01/16/25. Upon further investigation by the facility, R409's roommate reported R409 fell while attempting to stand from her unlocked wheelchair. Staff alerted the nurse of the fall, and she assessed R409, then all three of the staff members present lifted the resident from the floor. The resident was transported to the nurse's station. The investigative noted documented on 01/27/25 the facility attempted to contact the Licensed Nurse working on the shift when R409 fell to write a statement regarding the resident's record lacking a fall assessment or documentation the facility's fall protocol was followed. Observation on 02/03/25 at 02:54 PM revealed R409 in her wheelchair with her left arm in a sling and no facial grimace or signs of pain noted. Interview with Certified Nurse Aide (CNA) R on 02/10/25 at 11:25 AM revealed the resident was on fall precautions as she always tried to get up out of her bed. CNA R reported she heard the resident sustained a fracture of the pelvic area the last time she fell . Interview with CNA S on 02/11/25 at 12:50 PM revealed if a resident fell staff were to report it to the charge nurse, and not move the resident until an assessment was completed. During an interview on 02/10/25 at 02:20 PM Administrative Nurse D revealed she expected for all nurses to assess a resident with each fall, notify the provider, responsible party, and nurse manager. Administrative Nurse D stated she would re-educate any nurse who did not provide appropriate care to residents. The facility policy Fall and Fall Management dated March 2018 revealed facility staff will identify interventions related to resident's specific risk factors and causes to try to prevent the resident from falling and to try to minimize complications from the fall. The facility failed to assess R409 after a fall on 01/27/25. The facility further failed to document the fall and/or the resident's status after the fall until the resident transferred to a local hospital and was diagnosed with multiple fractures.

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 02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Excel Healthcare and Rehab Wichita	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 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. 36881 The facility reported a census of 102 residents. Based on observation, interview, and record review, the facility failed to conduct annual performance reviews for five of the five direct care staff reviewed, to ensure the residents receive adequate cares. Findings included: - Review of employment files for five sampled certified medication aides/certified nurse aides (CMA/CNA) employed at the facility for one year or more revealed all five lacked an annual performance review for: 1. CNA VV 2. CNA WW 3. CMA XX 4. CMA YY 5. CNA ZZ On 02/10/25 at 11:13 AM Administrative Staff A confirmed the five direct care/CMA/CNA reviewed lacked annual performance evaluations. She stated that the direct care staff employed over one year should have an annual performance review which included identified weaknesses and action plan to improve their performance. The nursing staff work throughout the facility with all the residents. The facility failed to provide a policy to address completion of a required performance review to identify direct care staff weaknesses and an action plan to improve staff performance. The facility failed to conduct annual performance reviews for five direct care staff, to ensure the residents received adequate cares.

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 02/11/2025

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F 0800

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs.

50659

The facility had a census of 102 residents. The sample included 21 residents. Based on observation, interview, and record review, the facility failed to serve the residents of the facility food, which was palatable, attractive, and served at the appropriate temperature.

Findings included:

- During an interview on 01/30/25 at 12:48 PM, Resident (R) 92 reported food does not always taste good and is served cold.

During an interview on 02/03/25 at 09:09 AM, R85 reported he felt like the kitchen staff do not care, the food is cold and does not taste well at times.

During an observation on 02/04/25 the prepared food was placed on the steam table at 10:30 AM and had reached correct cooked temperatures. The pureed corn temperature read at 105 degrees Fahrenheit (F). These food items were below the required serving temperature of 135 degrees F. Dietary Staff CC used the same thermometer to complete temperatures on all the food. She used a white cloth towel that she picked up from the counter and wiped off the thermometer after each food item temperature was obtained with the same white cloth towel. Dietary Staff CC wrote the temperatures on temperature log, and the food was served.

Review of the facility's grievance forms on 02/10/25 revealed the following:

On 10/09/24, R64 had completed a grievance form during his care plan meeting that the food he would receive could be hotter. The grievance lacked a response from dietary about the cold food concern.

On 12/06/24, R26 completed a grievance form that revealed food is cold, mislabeled, and meals are late. Dietary Staff BB responded on 12/07/24 that the kitchen would use warmers to keep the food hot, if the food was served not as hot as R26 would like it, she could let the staff know so food could be heated up or a fresh plate made.

On 01/15/25, R84 completed a grievance form that revealed R84 would go on a hunger strike due to the food being terrible. Dietary Staff BB responded on 01/15/25 and spoke to R84 about receiving her meal in a timely manner, and if she did have a concern to let Dietary Staff BB know.

On 01/21/25, R27 completed a grievance form that revealed food is cold. Dietary Staff BB responded on 01/23/25. However, the response lacked a action plan to prevent cold food.

Review of 12/17/24 Resident Council Meeting Notes revealed Ombudsman was present with 28 residents in attendance as well as Dietary Staff BB. Residents complained at that time the food was cold.

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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 02/11/2025
NAME OF PROVIDER OR SUPPLIER Excel Healthcare and Rehab Wichita		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/10/25 at 04:46 PM, Consultant Staff JJ (Registered Dietician) reported the temperatures for the pureed corn, hamburger patties, and peach cobbler were unacceptable, and she expected staff to serve all food at the correct holding temperatures. Consultant Staff JJ reported she expected the thermometer to be cleaned and sanitized in-between each food item temperature. During an interview on 02/11/25 at 10:44 AM, Administrative Staff A reported she had received several complaints about cold food served. She expected that the food should be served at the correct temperatures for a more palatable and enjoyable meal experience. Additionally, she reported she expected the thermometer to be cleaned and sanitized in-between each food item. The facility's policy Food Preparation and Service dated 2001 documented food and nutrition service employees would prepare, distribute, and serve food in a manner that complies with safe food handling practices. The danger zone for food temperatures was above 41 degrees F. or below 135 degrees F. The temperature range promotes rapid growth pathogenic microorganisms that could cause foodborne illness. The facility failed to serve the residents of the facility food, which was palatable, attractive, and served at the appropriate temperatures.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50659 The facility reported a census of 102 residents. Based on observation, interview, and record review, the facility failed to store, prepare, and serve food in a sanitary manner to prevent possible food-borne illness to the residents of the facility. Findings included: - Observation of the kitchen and food storage areas on 01/30/25 at 11:15 AM, revealed the following areas of concern: A large bag of panko crumbs with a ripped hole in the center of the bag, not sealed properly. There was a piece of plastic wrap laid partially over the ripped hole, no date when bag was opened. Several bags of pasta were opened and not sealed. A bag of honey granola no date labeled when opened. Two standing freezers in dry storage area had several unidentifiable frozen items in the door no dates and no labels noted. Turkey burgers no expiration date and no label. On the top shelf of standing freezer was a bag of cut up potatoes and some kind of pink meat that had no label or date. Dietary Staff BB (Dietary Manager) reported that the bag of potatoes and turkey that was noted was just used and should have been labeled and dated. On 01/30/25 at 11:28 AM observed in the walk in cooler two heads of lettuce opened no date. A bag of cheese no date and no label. A bag of some toasted bread no date, and no label. During an interview on 01/30/25 at 11:30 AM, Dietary Staff BB reported that the standing freezers generally were not used and confirmed that all the items dry, refrigerated or frozen should be labeled and dated when opened. During and observation on 01/30/25 at 11:45 AM the drain for the ice maker was not off the floor it was lying directly on the drain cover on the floor that was visibly dirty. Dietary Staff BB reported she was unaware that the ice machine drain had to be off the floor and confirmed the floor and drain were quite dirty and she reported she would let maintenance know. During an observation on 02/04/25 at 04:09 AM, the nourishment room east side of facility, the refrigerator had a gallon of open milk with no date when opened noted. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The ice machine drain was touching the drain on the floor. During an interview on 02/04/25 at 04:09 AM, Licensed Nurse (LN) K reported that he was unaware if food items required a date open label on them. During an interview on 02/11/25 at 10:44 AM, Administrative Staff A reported that she expected all food items to be labeled and stored per policy. Administrative Staff A reported the ice machine drains could not be touching the floor drain. The facility's policy Food Receiving and Storge dated 2001documented food shall be received and stored in a manner the complies with safe food handling practices. Dry foods that are removed from original packaging are labeled and dated. All foods stored in the refrigerator/freezer are covered, labeled and dated. The facility failed to prepare and serve food under sanitary conditions, to the residents of the facility appropriately to prevent the potential for food borne illness. This deficient practice had the potential to negatively affect the residents of the facility.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Excel Healthcare and Rehab Wichita	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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that a working call system is available in each resident's bathroom and bathing area.

41302

The facility reported a census of 102 residents with 21 residents sampled for review. Based on observation, interview, and record review the facility failed to be adequately equipped to allow residents to call for staff assistance through a communication system which relayed the call directly to a staff member or to a centralized staff work area from the resident's bedside, toilet, and bathing facilities.

Findings included:

- Tour on 02/03/25 at 02:30 PM, of the facility revealed call lights from any resident room or bathing facility area in the facility had only a light above the door that activated upon the call light being activated. When the call light was activated, the only indicator was the light above the door in the hallway that had no audible indicator nor to a console anywhere else in the facility.

Review of the November 2024 through February 2025 resident council minutes, including grievances, documented the council reported the following:

On 11/08/24 residents reported that call lights were not answered timely, with no response noted.

On 12/13/24 residents reported having a problem with long call lights with two to three hour wait times, many residents noted one hour wait times for call lights. With no response noted.

On 01/24/25 residents reported call lights were not answered timely. The response was answer call in timely both unit managers agree to watch out for this-solved.

On 02/10/25 residents reported that call light answer time had gotten a little better since they had gone to 12-hour shifts, since the first of the year. Last month Administration was invited to resident council and residents reported all lights being answered at appropriate times had been an on-going issue. Residents did believe that the administration had attempted to fix the call light problem.

On 01/30/25 during survey screening process, multiple residents reported long call light answering times.

During an interview on 02/04/25 at 04:09 AM, Certified Nurse Aide (CNA) T revealed she walked the halls to see which light was on, there were no pagers or board/screen to indicate which light was activated. She stated it was the same on both East and [NAME] halls.

During an interview on 02/04/25 at 04:21 AM, Licensed Nurse (LN) L revealed that the only way to know which or when a call light was activated was to walk down the halls on both the East and [NAME] sides.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 02/11/25 at 12:16 PM, Administrative Nurse F revealed there was no way to see down all three hallways in the bubble mirror or corner wall mirrors if sitting at the nurse station. Administrative Nurse F revealed you must actually come out from behind the desk and look down each hallway to see if and which call light was on. During an interview on 02/11/25 at 12:18 PM, CNA S revealed there was no way to see the call lights in the mirrors in you were seated at the nurse station, there are no bubble mirrors on the west side, you would actually have to come out of behind the nurse station to the middle of the hallway and look down all three hallways to see if a call light was going off. During an interview on 02/11/25 at 11:21 AM, Administrative Staff revealed none of the resident council complaints were reported to her. Administrative Staff revealed with the bubble reflector she believed you could see all the way down all the hallways. That it was all the staff's responsibility to answer call lights within their scope of practice and retrieve the correct staff if the request was out of their capacity. Confirmed the wait time should be no more than 15-20 minutes. The facility failed to produce a policy as requested. The facility failed to provide a call system that would ensure each resident had a direct communication with their caregivers that could delay response time and cause serious injury to the residents.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 36881 The facility reported a census of 102 residents. Based on observation, interview, and record review, the facility failed to ensure the continuing competence of nurse aides included annual mandatory training for abuse, neglect, and exploitation training. Findings included: - Review of employment files for five sampled certified medication aides/certified nurse aides (CMA/CNA) employed at the facility for one year or more revealed all five lacked continuing education, training provided for Abuse, Neglect, and Exploitation (ANE) for: 1. CNA VV 2. CNA WW 3. CMA XX 4. CMA YY 5. CNA ZZ On 02/10/25 at 11:13 AM, Administrative Staff A, confirmed the . above findings. She stated the facility should ensure the staff employed over one year should continuing education which include the mandatory Inservice training to for Abuse Neglect and exploitation (ANE). Additionally, she reported she could not guarantee the above noted staff had received mandatory in-services for ANE. The facility policy Abuse Prevention Program, dated 04/2021, documentation include the facility should provide staff orientation and training/orientation programs that include topics such as abuse prevention, identification, and reporting of abuse, stress management and handling verbally or physically aggressive residents. The the facility failed to ensure the continuing competence of nurse aides included annual mandatory training for abuse, neglect, and exploitation training.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 36881 The facility reported a census of 102 residents. Based on observation, interview, and record review, the facility failed to ensure the continuing competence of nurse aides but must be no less than 12 hours per year and Include dementia management training and resident abuse prevention training and address areas of weakness as determined in nurse aides' performance reviews which address the special needs of residents as determined by the facility staff. Findings included: - Review of employment files for five sampled certified medication aides/certified nurse aides (CMA/CNA) employed at the facility for one year or more revealed all five lacked 12 hours of continuing education, training provided based on identified weaknesses, or evidence of mandatory training which included Abuse, Neglect, and Exploitation for: 1. CNA VV 2. CNA WW 3. CMA XX 4. CMA YY 5. CNA ZZ On 02/10/25 at 11:13 AM, Administrative Staff A, confirmed the . above findings. She stated the facility should ensure the staff employed over one year should have a minimum of 12 hours of continuing education which include the mandatory Inservice training to include Abuse Neglect and exploitation (ANE) and address identified weaknesses in performance to ensure the residents receive adequate care. Additionally, she reported she had no way to assure all staff had received mandatory in-services. Such as ANE. The facility policy Abuse Prevention Program, dated 04/2021, documentation include the facility should provide staff orientation and training/orientation programs that include topics such as abuse prevention, identification, and reporting of abuse, stress management and handling verbally or physically aggressive. The facility failed to ensure the continuing competence of nurse aides, no less than 12 hours per year and Include dementia management training, resident abuse prevention/training, and address areas of weakness as determined in nurse aides' performance reviews which address the special needs of residents.