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	03/05/2025

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 0675 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Honor each resident's preferences, choices, values and beliefs. 50659 The facility reported a census of 100 residents with eight residents sampled and one resident reviewed for fecal impaction (accumulation of hardened feces in the rectum that the individual was unable to move), and constipation (difficulty passing stools). Based on observation, interview, and record review the facility failed to have an adequate system in place to identify the known signs and symptoms of fecal impaction for Resident (R) 77, who was required to have a large stool ball removed from his upper rectum, under anesthesia on 02/25/25 at 10:30 AM at the local hospital. This deficient practice placed all residents at risk in immediate jeopardy. Findings Included: - Review of the Electronic Health Record (EHR) documented R77 had a diagnosis of constipation. The 12/11/24 Quarterly Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of one, which indicated severely impaired cognition. R77 required total assistance with all activities of daily living (ADL) eating, dressing, mobility, transfers, bathing, oral care, and toileting. R77 was always incontinent of bowel. The 09/11/24 Annual MDS documented a BIMS score of one, which indicated severely impaired cognition. R77 required total assistance with all ADLs. R77 was always incontinent of bowel. The 09/27/24 Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) documented due to the resident's diagnosis, interventions included to apply incontinence devices as identified as appropriate for the resident, identify voiding patterns, monitor and document no output, increased pulse, increased temperature, altered mental status, change in behavior, and change in eating pattern. The resident's Care Plan documented R77 had impaired gastrointestinal function related to constipation, and included the following interventions: 10/18/22 - Staff were instructed to administer medications per physician orders. 10/18/22 - Staff were instructed to evaluate the resident for abdominal distention, bowel sounds and abdominal discomfort, after three days of no documented bowel movement. 10/18/22 - Staff were instructed to encourage adequate dietary and fluid intake. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0675 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	10/18/22 - Staff were instructed to monitor for signs and symptoms and or complaints of gastrointestinal upset, nausea, vomiting, and distention. Review of the Physician Orders lacked any orders for monitoring, or medications for, the resident's bowels. Review of the Bowel Incontinence in the EHR from 02/11/25 through 02/21/25 revealed staff documented R77 was incontinent of bowel movements (BMs) on the following days: On 02/12/25 at 10:59 AM, R77 had a medium bowel movement. On 02/13/25 at 11:18 AM, R77 had a medium bowel movement. On 02/15/25 at 09:25 AM, R77 had a small bowel movement. On 02/18/25 at 12:21 AM, R77 had a small bowel movement. On 02/19/25 at 03:21 AM, R77 had a medium bowel movement. All the BMs documented were charted as normal and formed. For all other days during that time frame no BMs were documented. The 02/21/25 at 03:19 PM Progress Note revealed R77 had attended therapy and became very lethargic and did not want to participate. Staff assessed his vital signs, and the resident had a temperature of 100.5 degrees Fahrenheit, pulse of 102 beats per minute, blood pressure of 168/94 millimeters of mercury (mmHg), and his Covid and flu swabs were negative. Administrative Nurse F attempted to straight catheterize (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid) the resident to obtain a urine sample, however the resident did not have any urine output. The facility transferred R77 to the local hospital for evaluation. The 02/21/25 at 04:55 PM emergency room Note revealed R77 complained of abdominal pain, decreased urine output, and lethargy. A computed tomography (CT scan- test that used x-ray technology to make multiple cross-sectional views of organs, bone, soft tissue and blood vessels) scan was completed and revealed a massive rectosigmoid (the part of the large intestine where the upper rectum meets the lower sigmoid colon) stool burden with associated rectal wall thickening. Findings were concerning for fecal impaction. The Note included they would consult a general surgeon on 02/22/25 for possible evaluation under anesthesia. The 02/25/25 at 10:30 AM Hospital Operative Report revealed R77 required surgery to have a large stool ball removed from his upper rectum under anesthesia. During a phone interview on 03/04/25 at 10:57 AM, R77's case manager at the hospital reported that R77 required the fecal impaction had to be removed while R77 was under anesthesia in the operating room on 02/25/25, as the medications and enemas administered to R77 during his admission from 02/21/25 thru 02/25/25 were not effective. (continued on next page)

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F 0675 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 03/04/25 at 11:23 AM, Certified Medication Aide (CMA) R reported that the nurse on duty would have to provide her with instructions to administer an as needed medication for any resident. CMA R reported she would look at the bowel movement report that should be printed every day, and if she noted that a resident did not have a bowel movement in three days she would let the nurse know. During an interview on 03/04/25 at 11:40 AM, Licensed Nurse (LN) G reported she would print out the bowel log every morning from the computer, and if a resident had more than three days of no bowel movement documented she provided the CMA direction to use standing orders of as needed milk of magnesia to be administered. LN G reported if a resident had an as needed medication for constipation already ordered she would provide the CMA direction to administer the ordered medication. Furthermore, LN G reported a small bowel movement documented in EHR would not count as a normal bowel movement. LN G reported the staff should document every day on every shift whether a resident had a bowel movement or no bowel movement. During an interview on 03/04/25 at 12:15 PM, Administrative Nurse F reported that bowel protocol is initiated when a resident did not have a normal bowel movement in three days. Administrative Nurse F reported the facility had standing orders for as needed bowel medications to relieve constipation. Administrative Nurse F reported that small BMs should not count as a normal BM and staff should chart every shift if a resident had a BM or not. Administrative Nurse F reviewed the BM charting in the EHR for R77 and confirmed some shifts were missing documentation and confirmed the resident he had not received any medications to treat constipation in the EHR. Administrative Nurse F reported R77 admitted to the hospital for a fecal impaction. During an interview on 03/04/25 at 01:09 PM, Administrative Staff A and Administrative Nurse B both confirmed R77 admitted to the local hospital with a bowel impaction. Administrative Staff A reported it was a concern that R77 required surgery to remove the fecal ball, but stated the resident was having normal bowel movements. Administrative Staff A and Administrative Nurse B could not answer if a small BM that was documented would count as a normal bowel movement. Administrative Staff A reported the facility did not have a bowel protocol policy and the facility used the standing orders for no BMs in three days. Administrative Nurse B reviewed the bowel movement documented in the EHR charting and reported she was concerned with the lack of charting noted for R77. During an interview on 03/04/25 at 01:49 PM, Certified Nurse Aide (CNA) N reported the resident did not have normal bowel movements right before he was discharged and stated it was a smear or visible mark of BM in R77's brief. CNA N reported she was told to document that as a small BM by the prior Director of Nursing of the facility. CNA N reported she noticed R77's breath started to smell like BM last month and his stool looked like putty and hard clay. CNA N said she reported that to the unknown agency nurse, as CNA N could not recall who the nurse was and stated the facility staffed a lot of agencies. CNA N reported she assisted an unknown, agency CMA to administer milk of magnesia to R77, prior to the transfer to the hospital. The facility lacked a policy for monitoring and documentation of bowel movements. (continued on next page)

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F 0675 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's Standing Orders from team health dated 04/04/24 documented if no BM in three days, give milk of magnesia (a medication is used for a short time to treat occasional constipation) 30 milliliters, by mouth. If no results within 24 hours, administer Lactulose (a synthetic sugar used to treat constipation) 20 milliliters, by mouth, every two hours, maximum three doses. If no results administer a Dulcolax suppository (a rectal medication used to treat occasional constipation) 10 milligrams. If no results administer a Fleets enema (is a saline laxative that provides reliable relief from occasional constipation that is inserted via rectum) once and notify the physician if no results. The facility failed to have an adequate system in place to identify the known signs and symptoms of fecal impaction for Resident (R) 77, who was required to have a large stool ball removed from his upper rectum, under anesthesia on 02/25/25 at 10:30 AM at the local hospital. This deficient practice placed all residents at risk in immediate jeopardy. On 03/04/25 at 06:20 PM, Administrative Staff A, Administrative Nurse B, Regional Nurse Consultant GG, and Regional Therapy Consultant HH were provided the Immediate Jeopardy (IJ) template and notified the facility failure for staff pervasive disregard for R77's dignity, in noting his breath smelled of bowel movement; lack of competent staff, who were incorrectly charting smear BM as small BM and lack of staff identification of R77's lack of urine output; lack of behavioral management and staff neglecting to recognize known clinical signs and symptoms of constipation and fecal impaction; Lack of staff training regarding resident behavioral issues and staff not providing adequate ADL assistance regarding bowel management placed R77s in immediate jeopardy to his health and safety, and placed all residents at risk. The deficient practice at F675 also constituted substandard quality of care at 42 CFR 483.24. The facility submitted an acceptable plan for removal of the immediate jeopardy on 03/04/25 at 08:46 PM which included the following: Identify those residents who have suffered, or are likely to suffer, a serious adverse outcome as a result of the alleged noncompliance: 1. R77 is currently at the hospital. 2. Clinical managers will interview interviewable residents for last BM, signs and symptoms of constipation, and fecal impaction. 3. CNAs will document BMs before the end of their shifts. 4. Nurses will assess non interviewable residents for signs and symptoms of constipation or fecal impaction. 5. If any residents are identified with constipation and fecal impaction, MD will be notified, and orders will be follow as needed. Specify the action(s) the facility will take to alter the process or system failure to prevent serious adverse outcome from occurring or recurring, and when the action(s) will be complete. (continued on next page)

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