| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175168 | A. Building<br>B. Wing | 03/19/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Excel Healthcare and Rehab Wichita | 7101 E 21st Street North<br>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 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40801<br><br>The facility reported a census of 105 residents with four residents included in the sample. Based on interview and record review the facility failed to ensure the staff administration of resident's medication met professional standards. The Certified Medication Aide administered Trazodone to Resident (R)2 at the incorrect time, and left R3's medication in her room, without observing the resident consume the medication and staff later found 15 medication cups with one gabapentin (medication used for nerve pain) and one tramadol (medication used for moderate to severe pain) in each cup and also found 19 tramadol pills in R3's drawer.<br><br>Findings included:<br><br>- R2's Electronic Medical Record (EMR) dated 05/29/24 indicated the following diagnoses: acute/chronic respiratory failure with hypoxia (persisting for a long period, often for the remainder of a person's lifetime, chronically poor airflow) and type two diabetes (a disease in which the body's ability to produce or respond to the hormone insulins is impaired, resulting in abnormal metabolism of carbohydrates and elevated levels of glucose in the blood and urine).<br><br>R2's Admission Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview Mental Status score of 10, indicating moderate cognitive impairment. R2 received daily insulin (a hormone produced by the pancreas that plays a crucial role in regulating blood sugar levels) in the seven-day, look back period.<br><br>The Care Plan revised 06/05/24 included R2 received a Trazodone which had a black box warning (BBW) to monitor for adverse events, such as suicidal thoughts and behaviors.<br><br>The EMR revealed an order dated 06/05/24 for Trazodone 50 milligrams (mg) by mouth at bedtime for insomnia/depression.<br><br>The Nurses Notes dated 01/05/25 at 05:00 PM revealed R2 had increased exhaustion the last couple of days around noon. The medication cart review revealed the nighttime Trazodone dose was placed with the noon medications and given at noon. The team notified the physician regarding the medication given at the wrong time and received orders to monitor the resident for side effects.<br><br>(continued on next page) |



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

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The Medication Error report dated 01/15/25 revealed R2's Trazodone 50 mg bedtime dose was in the morning medications which caused R2 increased exhaustion around noon the last couple of days. The report revealed R2 received the Trazodone in the morning and continued to receive the evening Trazodone dose also and noted the Certified Medication Aide (CMA) did not verify the medication prior to administration.<br><br>During an observation on 03/19/25 at 10:45 AM, R2 was in her bed and alert.<br><br>During an interview on 03/19/25 at 10:45 AM, R2 said she received her Trazodone at noon and it just made her sleepy. R2 said she did not have any other effects to the medication.<br><br>During an interview on 03/19/25 on 12:20 PM, Licensed Nurse (LN) G said R2 told staff she was tired a lot so we checked her medication and found the Trazodone in the noon slot instead of the bedtime. We notified the nurse practitioner regarding the medication error and received no new orders and continued to monitor R2 for side effects.<br><br>During an interview on 03/19/25 at 3:30 PM, Administrative Nurse D revealed they expected the staff to give the current medication at the correct time.<br><br>The facility's policy Administering Medication revision date April 2019, medications are administered in a safe and timely manner as prescribed. The individual administering the medications checks the label three times, to verify, the right resident, right medication, right dosage, right time and right method before giving the medication<br><br>The facility failed to ensure the medication administration met professional standards when the Certified Medication Aide administered the evening dose of R2's Trazodone at noon, and staff also administered R2's evening dose of Trazodone.<br><br>- Resident (R) 3's Electronic Medication Record (EMR) dated 09/21/24 revealed a diagnosis of cerebral vascular disease (a condition that affects blood flow to the brain).<br><br>The Annual Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview of Mental Status score of seven indicating severely impaired cognition. The MDS documented R3 received antidepressant medication in the seven-day lookback period.<br><br>The Quarterly MDS dated [DATE] indicated no changes from the 07/04/24 Annual MDS.<br><br>The Care Plan revised 04/26/24 indicated R3 had potential alterations in comfort related to arthritis (inflammation of a joint characterized by pain, swelling, heat, redness and limitation of movement) and aging process. The staff were to monitor for side effects of pain medication such as, increase agitation, restlessness, confusion, dizziness, and falls. The Tramadol (opioid pain medication) had a black box warning (BBW) because the use of tramadol exposed users to the risk of opioid addiction, abuse and misuse, which could lead to overdose and death.<br><br>The EMR orders included an order dated 02/13/25 to administer Tramadol 50 milligrams (mg), by mouth, three times a day for knee pain, and a 10/28/24 order for Gabapentin 100 mg, two tablets by mouth, two times a day for neuropathy.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The Nurses Notes dated 01/03/25 revealed the unit manager found 15 medication cups in the resident's room with one gabapentin and one tramadol in each cup. An hour later the roommate reported to staff R3 had more tramadol in her drawer and the staff entered the room and removed 19 more Tramadol.<br><br>On 01/03/25 the facility completed education regarding medication administration, noting when medication was being prepared and given to residents ensure the residents takes the medication while the medication aide or nurse is present, If the resident refuse to take the medication do not leave the medication in the room, return it to the medication cart.<br><br>During an interview on 03/19/25 at 11:00 AM, R3 said she had no idea why she had not taken her pills and said she would leave them everywhere. R3 said now the staff watch her take her medication all the time.<br><br>During an interview on 03/19/25 at 11:25 AM, Licensed Nurse (LN) H said the staff did not watch R3 take her medication and found 15 cups in R3's room with one gabapentin and one tramadol in each cup, and 19 Tramadol in R3's drawer.<br><br>During an interview on 03/19/25 at 03:30 PM, Administrative Nurse D revealed they expected staff to visualize the residents taking their medications.<br><br>The facility's policy Administering Medication revision date April 2019, medications are administered in a safe and timely manner as prescribed. The individual administering the medications checks the label three times, to verify, the right resident, right medication, right dosage, right time and right method before giving the medication.<br><br>The facility failed to ensure the medication administration met professional standards when the Certified Medication Aides did not observe the resident taking the medication and left the medication in her room, to which staff later found 15 medication cups with gabapentin and tramadol medication in each cup and also found 19 tramadol in her drawer. |