STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175180	A. Building B. Wing	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Excel Healthcare and Rehab Overland Park	5211 W 103rd Street Overland Park, KS 66207

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39752 The facility identified a census of 89 residents. The sample included three residents. Based on observation, record review, and interview the facility failed to ensure Resident (R) 1 remained free from abuse when Certified Nurse Aide (CNA) M tried to pull the call light out of R1's hands and pulled R1 from the bed onto the floor during the struggle. This abuse placed R1 at risk of pain, injury, and ongoing abuse. Findings included: - R1's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), difficulty walking, pain, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R1 required partial to moderate assistance from staff with toileting, and transfers from the toilet. R1 was independent with transfers from bed to chair and bed mobility. R1 had no behaviors. The high-risk drug class and Mood questionnaire lacked documentation. The Quarterly MDS dated [DATE] documented a BIMS score of 13 which indicated intact cognition. R1 required supervision or touching assistance from staff with transfers, walking, and toileting, but remained independent with bed mobility. R1 felt down, depressed, or hopeless two to six days a week. R1 had no behaviors. R1 took antidepressants. The Activities of Daily Living (ADLs) Care Area Assessment (CAA) and Falls CAA triggered but lacked analysis. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175180	A. Building B. Wing	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Excel Healthcare and Rehab Overland Park	5211 W 103rd Street Overland Park, KS 66207

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Care Plan initiated on 09/08/22 documented that staff were to monitor, record, and report R1's complaints of pain or requests for pain treatment related to R1's chronic back pain due to a history of previous back surgeries. Staff were to monitor and document R1's ability to perform ADLs and report any improvements or declines to R1's physician. R1's fall intervention revised on 07/25/23 directed staff to provide a safe environment and ensure a working and reachable call light for R1. R1's anxiety and depression interventions initiated on 08/21/23 directed staff to monitor and record occurrences of target behavior symptoms of pacing, disrobing, inappropriate response to verbal communication, violence, and or aggression towards staff or others and to document per facility protocol. The intervention initiated on 12/13/23 directed staff to monitor, document, and report to the nurse and or physician signs and symptoms of depression, including hopelessness, anxiety, sadness, insomnia, anorexia, verbalizing, negative statements, repetitive anxious or health-related complaints, or tearfulness. R1's plan revised on 02/19/24 directed staff to continue to frequently remind R1 to utilize staff and call for assistance for safety. The late entry Nurses Note on 06/28/24 at 10:35 AM documented R1 reported he was abused. R1 reported he had the call light in his hand and Certified Nurse Aide (CNA) M grabbed the call light and attempted to pull it out of R1's hand which caused R1 to fall out of bed and hit the floor. R1 stated he hurt his back and was abused. The Weekly Skin Evaluation dated 06/28/24 documented that R1 had a discolored area on his lower mid back. CNA M's unnotarized Witness Statement documented on 06/27/24, R1 was being rude to staff. CNA M reportedly got Licensed Nurse (LN) G to check on R1 and then changed assignments with CNA N. CNA M documented not going back into R1's room until sometime around 05:00 PM with CNA O to give R1 a new pull-up up then left his room. LN H's unnotarized Witness Statement documented on 06/27/24 CNA M came to LN H and stated R1 was verbally abusive to CNA M and R1 was pushing his call light non-stop. LN H and LN G went to check on R1 in his room and found R1 sitting on his bed, call light in hand pushing R1's call light incessantly. R1 was asked what happened, R1 stated he didn't want the CNA M to assist him. Administrative Nurse E's unnotarized Witness Statement documented on 06/28/24 at approximately 10:35 AM R1 reported he was holding his call light in his hand and CNA M grabbed the call light and jerked R1 to the floor. R1 reported he was abused by CNA M and hurt his back. LN G's unnotarized Witness Statement documented on 06/28/24 that R1 informed LN G that CNA M pulled his call light and pulled R1 out of his bed. R1 informed LN G that his back hurt. On 07/03/24 at 12;35 PM R1 leaned over in bed on his left elbow, uncovered in a pull-up. R1's bed was in the lowest position. R1 had a slight discoloration to his lower mid-back area. R1 stated that he was pulled out of his bed by CNA M and then CNA M assisted him back into bed. R1 stated that when the CNA pulled him from the bed, his back landed on the base of his bedside table and that is where the discoloration on his back came from. he got the mark on his back. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175180	A. Building B. Wing	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Excel Healthcare and Rehab Overland Park	5211 W 103rd Street Overland Park, KS 66207

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/03/24 at 11:05 AM Administrative Staff A stated that R1 reported abuse by CNA M and was adamant that he had been pulled out of his bed and landed on the silver foot of his over the bedside table. Administrative Staff A stated that she observed a small, bruised area on the lower part of his back, which appeared fresh and could have been caused by the foot of his over the bedside table. Administrative Staff A revealed the police were called and R1 was interviewed and reported the same thing that R1 reported to Administrative Staff A. Administrative Staff A stated R1 said CNA M had entered the room in the afternoon and attempted to pull the call light out of R1's hands because CNA M felt R1 was pushing his call light too much. R1 revealed to Administrative Staff A that he was then pulled off of the bed because he would not release the call light when CNA M pulled it. The facility's Abuse, Neglect and Exploitation policy lacked a date, documented the facility would provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. The facility would make efforts to ensure all residents were protected from physical and psychosocial harm. The facility failed to ensure R1 remained free from abuse when R1 was pulled out of bed by CNA M when CNA M tried to pull the call light out of R1's hands. This abuse placed R1 at risk of pain, injury, and impaired psychosocial well-being.