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	04/23/2025

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 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** 47834 The facility identified a census of 106 residents. The sample included three residents reviewed for falls and accidents. Based on observation, record review, and interview, the facility failed to investigate, determine causative factors, and implement relevant interventions to prevent further falls for Resident (R) 1, after R1 was found lying face down on the floor, at the bedside, on 11/08/24. Subsequently, R1 had another fall from the bed on 04/10/25, which resulted in a left femur (thigh bone) fracture and placed the resident at risk for further injuries and related pain. Findings included: - R1's Electronic Medical Record (EMR) documented diagnoses of Lewy body dementia (type of progressive brain disorder that leads to a decline in thinking, reasoning, and independent function), benign brain neoplasm (a non-cancerous tumor within the brain that usually grows slowly and does not spread), malignant neoplasm of the parietal lobe (a cancerous tumor located in the top and back of the brain), reduced mobility, weakness, and cerebral infarction (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] documented a Brief Interview for Mental Status (BIMS) score of seven, which indicated severe cognitive impairment. The MDS documented R1 used a wheelchair and was dependent on staff for mobility. The MDS documented R1 was dependent on staff for bed mobility, transfers, and toileting. The MDS documented she had no falls since admission or the prior assessment. The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 01/29/25, documented R1 had diabetes (when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), respiratory problems, and cancer as medical problems that could impact cognition. The CAA further documented R1's cognitive loss and dementia were addressed in the care plan. The Functional Abilities (Self-Care and Mobility) CAA, dated 01/29/25, documented R1 had changing cognitive status and mood decline as possible underlying problems that may affect function. The CAA further documented that functional abilities were addressed in the care plan. The Falls CAA did not trigger. (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 0689 Level of Harm - Actual harm Residents Affected - Few	R1's Care Plan, with an initiated date of 05/24/17, documented R1 had restless leg syndrome (a condition that causes a very strong urge to move the legs). R1's Care Plan with an initiated date of 04/21/19 documented R1 was at risk for falls related to deconditioning, gait, and balance problems. R1's Care Plan with an initiated date of 01/12/23, documented R1 had an activity of daily living (ADL) self-care performance deficit related to activity intolerance and dementia. An intervention with an initiated date of 01/11/24 documented R1 required two staff members to reposition and turn in bed. An intervention with an initiated date of 01/11/24 documented R1 required a mechanical Hoyer (total body mechanical lift) with the assistance of two staff for transfers. An intervention with an initiated date of 11/11/24 directed staff to send R1 to the hospital for evaluation and treatment. An intervention with an initiated date of 04/10/25 directed staff to keep R1s's bed in the lowest position. An intervention with an initiated date of 04/11/25 directed staff to place a call for the hospice nurse to come to the facility for further evaluation, a STAT x-ray was ordered, then canceled, and R1 was sent to the emergency room (ER) for evaluation and treatment. An intervention with an initiated date of 04/23/25 documented the intervention upon return from the hospital hospice would provide a bolster overly (type of mattress used to help prevent falls from bed) for the bed, fall mat at the bedside, and comfort medications for pain as needed (PRN). R1's Care Plan lacked evidence of additional fall interventions related to the fall that occurred on 11/08/24, where R1 was found face down, on the floor at the bedside. An Alert Note dated 11/08/24 at 07:19 PM documented staff observed R1 lying face down on the floor at the bedside. Staff assessed R1and no injuries were observed; the note further documented R1 could not do range of motion (ROM) as R1 stated she was in pain. The note documented R1 had no visible injury and her skin was intact. Staff obtained an order to send R1 to the hospital for evaluation. An IDT - Fall note dated 11/11/24 at 11:18 AM documented R1 had a fall on 11/08/24 at 06:30 PM. The note documented the root cause analysis (RCA) was R1 did not know what happened, and just rolled out of bed. The note recorded R1 was unable to describe what she was doing at the time of the fall. The note further documented a prior intervention was to keep R1's call light within reach. The note documented the current intervention was staff sent R1 to the hospital for evaluation and treatment. No other interventions were documented in the IDT - Fall note. A Nurse's Note dated 04/10/25 at 06:06 AM documented the charge nurse was called to R1's room by the certified nurse aide (CNA) on duty and informed R1 was on the floor. The note documented that upon entering the room, R1 was lying on the floor next to her bed. Staff assisted R1 back to bed and notified hospice of the fall. The note documented R1's complaint of pain in her left leg. Staff notified the provider of R1's fall, and left a message for R1's emergency contact. A Nurse's Note dated 04/11/25 at 03:23 AM documented staff contacted hospice regarding R1's continued complaint of pain in her left leg with movement due to her fall that morning. The note further documented hospice ordered a STAT (immediate) X-ray of R1's left hip and femur but then called back and recommended sending R1 to the hospital for evaluation and treatment. The note documented R1 was transported to the emergency room (ER) at 03:05 AM. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R1's hospital document Trauma History and Physical Examination dated 04/11/25, documented R1 was activated as a Trauma Consult after sustaining a left femur fracture from an unwitnessed fall at R1's facility. The document further recorded the fall happened at approximately 06:00 AM the previous morning (04/10/25). R1 was a hospice patient and was evaluated by hospice twice on 04/10/25, and eventually made the decision to call Emergency Medical Services (EMS) to bring R1 to the ER because R1 continued to experience pain in her left leg. The document recorded R1 was a poor historian due to significant cognitive deficits. R1 was able to tell the provider her name and said pain when the provider touched R1's left leg. An Admission Summary (Admit/Re-admit) note dated 04/11/25 at 03:50 PM, documented R1 came back to the facility via stretcher with a diagnosis of a left femur fracture and blood clots. The note recorded R1's Durable Power of Attorney (DPOA) had a discussion with the hospital team and decided not to do aggressive treatment because the DPOA did not want R1 to be in pain. The note documented R1 was on comfort care with hospice and the hospice nurse was at the bedside. CNA M's Witness Statement notarized on 04/11/25, documented CNA M was in the hallway and suddenly heard R1 yelling; R1's call light was going off. CNA M went into R1's room and found R1 lying on the floor beside her bed, indicating R1 fell out of bed. CNA M documented staff helped R1 roll over onto her back and placed a pillow behind R1's head, then quickly left and got a nurse. Licensed Nurse (LN) G's Witness Statement notarized on 04/11/25, documented on 04/10/25 at approximately 05:50 AM, LN G was approached by the CNA taking care of R1, who stated they found R1 on the floor in R1's room. The statement documented that upon entering the room, R1 was lying on the floor next to her bed; R1 was slightly turned to her right side, facing the door. LN G documented she asked R1 what happened and how R1 fell , R1 hesitated and stated she did not know. LN G documented staff completed an assessment and obtained vital signs. LN G documented staff did not observe any visible injury, and R1 had responded no when asked if she was in pain. The statement further documented staff transferred R1 to bed, and while repositioning R1 in bed, R1 complained of pain in her left leg when it was moved. LN G documented they gave R1 pain medication and called hospice and the nurse practitioner regarding R1's fall. The facility was unable to provide an investigation related to R1's fall on 11/08/25. On 04/23/25 at 03:05 PM, an observation revealed R1 rested in bed. R1's bed had a bolstered mattress overly in place and a fall mat was on the floor beside R1's bed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 04/23/25 at 01:44 PM, Administrative Nurse D stated R1 had one other unwitnessed fall on 11/08/24 and said she thought R1 had rolled out of bed then. Administrative Nurse D stated R1 was sent to the hospital for evaluation and treatment as R1 reported having pain. Administrative Nurse D stated there were no injuries from that fall, and the facility did not have floor mats in place prior to the fall on 11/08/24 or afterward; the fall mats were put in place only after the fall on 04/10/25. Administrative Nurse D reviewed R1's EMR and plan of care and verified the only fall intervention added, in relation to R1's fall out of bed on 11/08/24, was to send R1 out for evaluation. Administrative Nurse D stated she did not see any other interventions added in relation to that fall, on R1's Care Plan or in the EMR. She said R1 was not someone who had frequent falls. Administrative Nurse D stated, after a fall, staff should absolutely add fall interventions, and staff met each morning to review any falls and interventions. Administrative Nurse D stated there was no fall investigation for the fall on 11/08/24; however, the facility performed a risk assessment and had an interdisciplinary team (IDT) note that recorded an intervention to send the resident out for evaluation. Administrative Nurse D stated she did not see any other interventions documented in the IDT note. Administrative Nurse D stated there was no further documentation related to the fall on 11/08/24 aside from the IDT note dated 11/11/24 at 11:18 AM and the alert note dated 11/08/24 at 07:19 PM. On 04/23/25 at 03:13 PM, LN H stated he was not in the facility the day R1 fell on [DATE]. LN H stated when a resident fell , he would assess the resident for injury and pain, check ROM, perform neurological checks, assess alertness, and compare to the resident's baseline. LN H further stated he would contact the provider for potential orders, and notify the Director of Nursing (DON), Assistant Director of Nursing (ADON), and the resident's emergency contact. LN H stated the nurse would perform a post-fall assessment and put fall interventions in place. LN H stated that a bolster mattress, a fall mat on the floor at the bedside, and having the bed in the lowest position would be appropriate interventions for a resident who fell out of bed. LN H stated it would be appropriate to add interventions after a resident's initial fall. LN H stated he believed the MDS coordinator updated the residents' care plan with fall interventions after the fall risk assessment was completed with recommended interventions. On 04/23/25 at 03:35 PM, Administrative Nurse D stated the MDS coordinator, herself, or the ADON updated the resident's care plan with fall interventions. Administrative Nurse D stated it would have been appropriate to add interventions related to R1's fall on 11/08/24 and believed the team must have missed adding them at the time. Administrative Nurse D stated she believed the fall on 11/08/24 was related to R1 having a urinary tract infection (UTI), and the fall on 04/10/25 was more so related to R1 having terminal restlessness. Administrative Nurse D stated R1 was not a frequent faller and only fell when R1 had something else going on, such as the UTI and restlessness. The facility's Falls and Fall Risk Managing policy with a revision date of March 2018, documented based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling.