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	09/11/2024

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

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634 The facility identified a census of 87 residents. The sample included 20 residents. One resident was sampled for reasonable accommodations of resident needs and preferences. Based on observation, record review, and interview, the facility failed to ensure Resident (R)44's built-up utensils (foam grip on regular utensils), and a divided plate was provided. This deficient practice left R44 vulnerable to unmet care needs due to the inability to feed herself. Findings included: - R44's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), obesity due to excess calories, hypertension (HTN-elevated blood pressure), edema (swelling resulting from an excessive accumulation of fluid in the body tissues), anemia (an inadequate number of healthy red blood cells to carry adequate oxygen to body tissues), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), weakness, hypoxia (inadequate supply of oxygen) and dysphagia (swallowing difficulty). The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of four which indicated severely impaired cognition. The MDS documented that R44 was dependent on staff for eating. The MDS documented R44 was impaired on both sides of her body. R 44's Nutrition Care Area Assessment (CAA) dated 10/18/23 documented R44 required moderate assistance with activities of daily living (ADLs) and was incontinent of bowel and bladder. R44's Care Plan dated 08/09/24 documented R44 was able to hold a cup, self-feed, and eat finger foods independently. R44's plan of care documented R44 used a divided plate and built-up silverware; staff were to set up her tray. R44's EMR under the Orders tab documented a diet order dated 03/21/23 to give pureed texture with thin-consistency liquids. R44 was to have a lidded cup with a handle, a lip plate, and modified utensils- a foam grip on regular utensils. On 09/10/24 at 09:35 AM R44's had a plate of biscuits and gravy on her bedside table. The plate was a regular plate (not divided). There were two regular spoons, and the spoons did not have a foam grip. R44 did not receive a divided plate, R44 asked for a divided plate, and staff scraped her food from a regular plate to a divided plate. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/11/24 at 10:05 AM R44's had a tray with the lid sat on her bedside table. R44 had a regular spoon on the tray, the spoon did not have a foam grip. On 09/09/24 at 07:20 AM, R44 stated she was supposed to get a divided plate and gripped silverware. R44 stated she must ask for her plate and silverware. On 09/11/24 at 01:06 PM Certified Nurse's Aide (CMA) M stated dietary was supposed to make sure the residents got the right plates and silverware. On 09/11/24 at 01:19 PM, Licensed Nurse (LN) E stated she was unsure, but she thought dietary would send the plates and silverware, and nursing would ensure residents have what they need. On 09/11/24 at 02:19 PM, Certified Nurse Aide (CMA) D stated dietary and nursing staff were supposed to ensure each resident got what they needed to ensure they were able to do the most for themselves. On 08/14/24 at 12:58 PM Administrative Nurse D stated diet orders go to the dietary department, and the dietary department sends the plates. Administrative Nurse D said the nursing staff was to ensure the correct utensils were given to each resident. The facility did not provide an accommodation of needs policy. The facility failed to ensure R44's divided plate and built-up utensils were provided. This deficient practice left R44 vulnerable to unmet care needs due to the inability to feed herself.

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F 0576 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure residents have reasonable access to and privacy in their use of communication methods. 45668 The facility identified a census of 87 residents. The sample included 20 residents. Based on observation, record review, and interviews, the facility failed to provide mail delivery on Saturdays. Findings Included: - On 09/10/24 at 03:01 PM the Resident Council members reported that the facility did not provide mail services for the residents on Saturdays. The council reported the mail was stored over the weekend at the east nurse's station and distributed the following Monday. They stated that the weekend activity staff that used to pass it out stopped coming. On 09/10/24 at 01:05 PM Activities Staff Z stated she worked Monday through Friday. She stated that she previously had an assistant who provided activities and mail on weekends, but he no longer worked weekends. She stated she tried to come in on weekends but was often unable to do so on most weekends. On 09/11/24 at 01:06 PM Certified Nurse's Aid (CNA) M stated he was not aware of mail being handed out on Saturdays. He stated activities usually handed out the mail but they did not work on weekends. He stated he didn't think mail was given out on the unit on Saturdays. On 09/11/24 at 02:24 PM Administrative Nurse D stated the mail was passed out by activities staff on weekdays. She stated it would be dropped off at the reception desk but was not sure who was responsible for it on the weekends. The facility's Mail policy (undated) indicated the facility would ensure each resident was allowed to communicate privately with individuals. The policy indicated mail will be delivered unopened and within 24 hours of it being accepted by the facility. The facility failed to provide mail delivery on Saturdays.

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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. 41037 The facility identified a census of 87 residents. The sample included 20 residents with three reviewed for Center for Medicare and Medicaid Services (CMS) Beneficiary Liability notices. Based on record review and interviews, the facility failed to provide form CMS-10055, Skilled Nursing Facility (SNF) Advance Beneficiary Notice of Non-coverage (ABN) which included the estimated cost for continued services for skilled services to the resident or their representative for Resident (R) 18, R33, and R39. This deficient practice placed three residents at risk for uninformed decisions. Findings included: - A review of R18's Electronic Medical Record (EMR) documented that the Medicare Part A episode began on 03/26/24 and ended on 05/03/24. R18 remained in the facility for custodial care. The facility issued R18 form CMS-R-131 that lacked the cost of continued therapy instead of the required CMS-10055. A review of R33's EMR documented that the Medicare Part A episode began on 02/24/24 and ended on 03/19/24. R33 remained in the facility for custodial care. The facility issued R33 form CMS-R-131 that lacked the cost of continued therapy instead of the required CMS-10055. A review of R39's EMR documented that the Medicare Part A episode began on 04/17/24 and ended on 05/13/24. R39 remained in the facility for custodial care. The facility issued R39 form CMS-R-131 that lacked the cost of continued therapy instead of the required CMS 10055. On 09/11/24 at 09:55 AM, Social Services X stated the ABN form the facility had instructed her to use was different from the form CMS-R-131. She stated the director of nursing had provided her with an updated CMS-10055 form she was to start issuing in October 2024. Social Services X stated the ABN should include the cost for the resident to continue skilled therapy. On 09/11/24 at 11:10 AM, Administrative Staff A stated the facility would start issuing the updated CMS 10055 form. The facility's Medicare Advance Beneficiary and Medicare Non-Coverage Notices policy last revised 09/2022 documented that residents were informed in advance when changes would occur to their bills. The facility issues the Skilled Nursing Facility Advance Beneficiary Notice (CMS form 10055). The facility failed to issue R18, R33, and R39 the correct SNF ABN form CMS-10055 that included the cost to the resident for continued skilled therapy. This deficient practice placed three residents at risk for uninformed decisions.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037 The facility identified a census of 87 residents. The sample included 20 residents with one resident reviewed for hospitalization . Based on observation, record review, and interviews, the facility failed to provide written notice of transfer/discharge as soon as practicable for Resident (R) 39's facility-initiated transfers. This deficient practice placed R39 at risk of uninformed choices and miscommunication regarding care needs. Findings included: - R39's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), atrial fibrillation (rapid, irregular heartbeat), hypertension (HTN-elevated blood pressure), and sleep apnea (a disorder of sleep characterized by periods without respirations). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 14 which indicated intact cognition. The Quarterly MDS dated [DATE] documented a BIMS score of 14 which indicated intact cognition. R39's Psychotropic Drug Use Care Area Assessment (CAA) dated 05/30/24 documented he was at an increased risk of adverse side effects and that staff would continue to monitor for adverse reactions to his medications. R39's Care Plan dated 12/27/23 documented that staff would monitor, document, and report any signs or symptoms of fluid [NAME] to the physician. R39's EMR under the Progress Notes tab revealed a Nurse's Note dated 04/13/24 at 06:13 PM that which documented R39 was transferred to the hospital and admitted . On 05/11/24 at 07:22 PM a Nursing Progress Note documented R39 was readmitted to the facility from the hospital. On 06/13/24 at 00:47 AM a Nursing Progress Note documented R39 was transported to the hospital and admitted . The facility was unable to provide evidence a written notice of transfer or discharge notification was provided to R39 or the legal representative when R39 transferred to the hospital on the above dates. On 09/10/24 at 03:11 PM, R39 laid flat on his bed with his continuous positive airway pressure (CPAP-ventilation device that blows a gentle stream of air into the nose to keep the airway open during sleep) on as he slept. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/11/24 at 09:55 AM, Social Services X stated she has not ever sent any written notification to a resident or their representative regarding a transfer and admission to the hospital. Social Services X stated she believed the nursing staff notified the resident's representative by phone. On 09/11/24 at 01:23 PM, Administrative Nurse E stated she was not sure who was responsible for sending a written notification to the resident's representative when the resident was transferred and admitted to the hospital. On 09/11/24 at 01:23 PM, Administrative Staff A stated the facility notified the resident's representative by phone when a resident was transferred to the hospital. The facility was unable to provide a policy related to written notification to a resident's legal representative for a facility's-initiated transfer and admission to the hospital. The facility failed to provide written notice of transfer/discharge as soon as practicable for R39's facility-initiated transfers. This deficient practice placed R39 at risk of uninformed choices and miscommunication regarding care needs.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. 45668 The facility reported a census of 87 residents. The sample included 20 residents with 20 reviewed for Minimum Data Set (MDS) completion. Based on interviews and record review, the facility failed to complete a quarterly assessment no more than 92 days from the last MDS for Resident (R)84 and R17. This deficient practice placed the residents at risk for unidentified and unmet care needs. Findings included: - A review of R84's Electronic Medical Record (EMR) revealed she had an Admission MDS completed 04/30/24 with the next quarterly assessment reference date (ARD) set as 07/31/24. R84's EMR indicated a Quarterly MDS was started on 07/26/24 but never completed. The EMR indicated the MDS was In Progress. R84's EMR indicated no completed and accepted MDS assessments since 04/30/24. A review of R17's EMR revealed he had a Quarterly MDS completed 04/19/24 with the next quarterly ARD set as 07/19/24. R17's EMR indicated his Quarterly MDS was started on 07/19/24 but never completed. The EMR indicated the MDS was In Progress. R17's EMR indicated no completed and accepted MDS assessments since 04/19/24. On 09/12/24 at 02:09 PM Administrative Staff C stated she took over completing the MDS assessments after the ownership change. She stated she completed the MDS assessments remotely. She stated the nurses, social workers, and therapists reported to her any changes and pertinent information as they worked with the residents. She stated the facility is required to update the MDS assessments quarterly, annually, and with significant changes for the residents. She stated after the facility ownership change, she reviewed the system, flagged assessments that were due, and was trying to update them. She stated she was not aware that R17 and R84's assessments were past due. She stated the system would usually flag them and alert her. According to the Long-Term Care Resident Assessment Instrument (RAI) Manual, the facility must complete a Quarterly MDS assessment within 92 days of the previous assessment ARD. The facility failed to complete Quarterly MDS assessments for R84 and R17 within the required 92-day timeframe. This deficient practice placed the residents at risk for unidentified and unmet care needs.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 49634 The facility identified a census of 87 residents. The sample included 20 residents with seven residents reviewed for activities of daily living (ADL) care. Based on observation, record review, and interviews, the facility failed to ensure bathing was provided for Resident (R) 44 who required assistance from staff to complete the care. This deficient practice placed resident R44 at risk for complications related to poor hygiene and impaired dignity. Findings included: - R44's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), obesity due to excess calories, hypertension (HTN-elevated blood pressure), edema (swelling resulting from an excessive accumulation of fluid in the body tissues), anemia (an inadequate number of healthy red blood cells to carry adequate oxygen to body tissues), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), weakness, hypoxia (inadequate supply of oxygen) and dysphagia (swallowing difficulty). The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of four which indicated severely impaired cognition. The MDS documented R44 was dependent on staff for all ADLs except bathing was not applicable. The MDS documented R44 was impaired on both sides of her body. R44's Cognitive Loss and Dementia Care Area Assessment (CAA) dated 10/18/23 documented R44 documented R44 required moderate assistance with activities of daily living (ADLs) and was incontinent of bowel and bladder. R44's Care Plan dated 01/24/23 documented R44 was totally dependent on staff to provide bathing or showers on preferred day and evening shifts. R44's Resident Bath Sheet documented R44 had a bed bath or shower on 08/09/24, 08/13/24, 08/15/24, 08/22/24, and 08/31/24. The records did not reveal any documentation for bathing from 08/31/24 through 09/10/24. On 09/09/24 at 09:34 AM, R44 lay in her bed. Her hair appeared greasy. R44 had long fingernails on her left hand. On 09/10/24 at 09:35 AM R44 laid on her back looking at her breakfast tray. Her hair appeared greasy. R44 had long fingernails on her left hand. On 09/09/24 at 09:34 AM, R44 stated she had not had a shower or bath since 08/31/24. R44 stated she had been told by staff that there was no hot water and that she would have to wait. R44 stated she does not like it when she does not get a bath, she stated it makes her itch. (continued on next page)

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	175180	A. Building B. Wing	09/11/2024

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/11/24 at 01:06 PM, the Certified Nurse Aide (CNA) M stated CNAs fill out bath sheets to ensure residents get baths. He stated nursing staff were to check the bath sheets to ensure baths were given. On 09/11/24 at 01:19 PM Administrative Nurse E stated CNAs fill out bath sheets. She stated she was unsure if the baths were documented in the EMR. Administrative Nurse E stated nurses should be following up with staff to ensure the baths were given. On 09/11/24 at 02:24 PM Administrative Nurse D stated the facility fills out bath sheets to track bathing. She stated the CNAs should be letting the nurses know if a resident was refusing baths or checking sheets to ensure baths or showers were given. The facility's Bathing policy documented staff was to notify the supervisor if the resident refuses the shower or bath, notify the physician if any skin area may need to be treated, and report other information in accordance with facility policy and professional standards of practice. The facility failed to provide consistent bathing for R44 who required assistance with bathing. This deficient practice placed R44 at risk for complications related to poor hygiene and impaired dignity.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. 45668 The facility identified a census of 87 residents. The sample included 20 residents. Based on interviews and record reviews, the facility failed to provide activities on the weekends that met the residents' interests, social needs, and preferences. This placed the residents at risk for boredom, isolation, and decreased quality of life. Findings included: - A review of the facility's Activity Calendar for July, August, and September 2024 was completed. The review revealed the residents were only offered self-led activities in August and September on Saturdays and Sundays. The calendar revealed there were no structured or group activity opportunities on the weekends. On 09/10/24 at 03:01 PM, the Resident Council reported the facility frequently did not provide activities on Saturdays and Sundays. The Council indicated there was no available staff to direct or assist with activity on the weekend. On 09/10/24 at 01:05 PM Activities Staff Z stated she worked Monday through Friday. She stated she had an assistant who provided activities and mail on weekends, but he no longer worked weekends. She stated she tried to come in on weekends but was unable to most weekends. On 09/11/24 at 01:06 PM, Certified Nurse's Aide (CNA) M stated activities staff were not in the facility on weekends and the residents were provided self-led activities without staff involvement. The facility's Activities policy revised 05/2013 indicated the facility would ensure residents were provided with activities that reflect their choices and interests. The policy indicates the facility will encourage each resident to attend activities that meet each resident's interests, hobbies, worship, beliefs, and social needs. The facility failed to provide activities on the weekends that met the residents' interests, social needs, and preferences. This placed the residents at risk for boredom, isolation, and decreased quality of life.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45668 The facility identified a census of 87 residents. The sample included 20 with six 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 interviews, record review, and observations, the facility failed to ensure Resident (R) 37, and R26s' low air-loss mattress pump, used to prevent pressure ulcers, was set and functioning for adequate pressure relief. This deficient practice placed the residents at risk for complications related to skin breakdown and pressure ulcers. Findings Included: - The Medical Diagnosis section within R37's Electronic Medical Records (EMR) noted diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), and Parkinsonism (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness). R37's Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of five indicating severe cognitive impairment. The MDS indicated he had upper and lower extremity impairments. The MDS indicated he was dependent on staff assistance for oral hygiene, bed mobility, toileting, bathing, dressing, and transfers. The MDS indicated he was at risk for the development of 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). The MDS indicated he had pressure-relieving devices for his chair and bed. The MDS indicated bed rails were not used. R37's Functional Abilities Care Area Assessment (CAA) completed 01/03/24 indicated he required assistance with his activities of daily living (ADLs) related to his generalized weakness, decreased safety awareness, and medical diagnoses. The CAA indicated other risk factors for R37 including urinary incontinence, skin breakdown, falls, and pressure ulcers. R37's Care Plan initiated 03/09/22 indicated he required partial to moderate assistance with bed mobility, dressing, personal hygiene, toileting, bathing, and transfers. The plan indicated he was at risk for pressure ulcers and had a low air-loss mattress on his bed. The plan lacked guidance related to the weight and comfort settings of his low air-loss mattress. R37's EMR under Physician Orders lacked documentation related to his low air-loss mattress. R37's EMR under Evaluations revealed a Braden Scale assessment was completed on 06/17/24. The assessment revealed a score of 17 indicating he was at risk for pressure ulcers. R37's EMR under the Weights and Vitals section revealed he weighed 206 pounds (lbs.) on 09/10/24. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the low air-loss mattress manufacturer's operation (Drive Model #14027) manual indicated the mattress system was intended to reduce the incidence of pressure ulcers while optimizing comfort. The manual indicated the mattress pump's pressure levels and firmness were preset based on the weight range and comfort settings. The manual indicated an optimal bed system assessment should be conducted on each patient by a qualified clinician or medical provider to ensure maximum safety. The manual indicated the usage of bed rails with the air mattress system should be assessed based on the risk of entrapment. On 09/09/24 at 07:23 AM an inspection of R37's room revealed a bordered mattress and bed cane (a side rail device attached to the bed to improve bed mobility) on both sides of his bed. R37's bed had a Drive Model low air-loss mattress system set at 350 lbs. The mattress pump weight ranged from 50lbs. to 350lbs. and was adjustable within 30 lbs. intervals. On 09/11/24 at 12:55 PM, R37 was in the television room. R37's low air-loss mattress remained set at 350 lbs. R37's bilateral bed canes remained in place on his bed. On 09/11/24 at 01:06 PM, Certified Nurse Aide (CNA) M stated the low air-loss beds were brought in and set by central supply. He stated staff checked to make sure the beds were working and on the correct setting. He stated the mattresses were set up by the resident's weight. He stated he was not sure if the EMR provided guidance for what specific settings each resident should have for their air pumps. On 09/11/24 at 01:19 PM Administrative Nurse E stated the low air-loss mattresses were brought in and the weights were programmed upon installation. She stated staff were expected to check the settings each shift. She stated the pumps were set up based on the resident's weight. She stated the care plan should identify if the resident preferred a different weight or comfort setting. On 09/11/24 at 02:24 PM Administrative Nurse D stated the low air-loss mattress system was installed by central supply based on the resident's weight. She stated the care plan should indicate the resident's weight and if the setting could be adjusted for comfort. She stated direct care staff was expected to ask nurses if they had any questions related to the mattress settings. The facility did not provide a policy related to pressure ulcer prevention or the use of low air-loss mattress systems as requested. The facility failed to ensure R37's low air-loss mattress pump was appropriately set to his current weight or indicate his weight settings could be altered per his preferences and indicate those preferences. This deficient practice placed R37 at risk for complications related to skin breakdown and pressure ulcers. 49634 (continued on next page)

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	175180	A. Building B. Wing	09/11/2024

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- R26's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of lack of coordination, restlessness and agitation, hypertension (HTN-elevated blood pressure), depression (a mood disorder that causes a persistent depression feeling of sadness and loss of interest), dysphagia (swallowing difficulty), weakness, pseudobulbar affect (a neurological condition that causes people to experience uncontrolled and inappropriate laughing or crying), abnormal weight loss, and Huntington's disease (a rare abnormal hereditary condition characterized by progressive mental deterioration, a disabling central nervous system movement disorder). The Quarterly Minimum Data Set (MDS) dated 06//14/24 R26 documented a Brief Interview of Mental Status (BIMS) score of three which indicated severely impaired cognition. The MDS documented R26 was at risk for developing pressure ulcers. The MDS documented R26 was dependent on staff for all activities of daily living (ADLs). The MDS documented R26 has a pressure-reducing device on her chair and bed. R26's Pressure Ulcer Care Area assessment dated [DATE] documented R26 had pressure ulcer risk with contributing factors including urinary and bowel incontinence and decreased mobility. R26's Care Plan dated 01/20/24 documented R26 was at risk for impaired skin integrity and pressure ulcer development related to impaired mobility, thrashing, and spastic movements due to Huntington's disease and incontinence. The plan of care for R26 documented she had a pressure-reducing mattress on her bed and a pressure-reducing cushion in her Broda chair (specialized wheelchair with the ability to tilt and recline). The plan of care documented nursing was to do weekly skin assessments with any skin issues identified to be reported and addressed. The plan lacked direction related to the use of a low air-loss mattress and appropriate weight or comfort settings. R26's Braden Scale for Prediction Pressure Sore Risk dated 06/18/24 documented a score of 12 indicating a high risk for pressure ulcers. R26's EMR under the Orders tab revealed the following physician's orders: Left ankle preventative treatment, nursing to apply Skin-prep (liquid skin barrier) and a silicone foam dressing one time a day every Monday and Thursday, dated 01/18/24. Apply barrier cream to the coccyx (area at the base of the spine) every shift for excoriation and as needed (PRN), dated 03/14/24. Left inner foot preventative- nursing to apply Skin-prep and a silicone foam dressing one time a day every Monday and Thursday, dated 04/08/24. R26's EMR under the Weights and Vitals tab revealed a weight of 107.2 pounds on 08/06/24. On 09/09/24 at 07:24 AM, R26 laid on her back in bed. R26's low air-loss mattress was not plugged in and was deflated. R26's mattress was set at 350 pounds. On 9/10/24 at 07:06 AM R26 laid on her back in bed. R26's low air-loss mattress was set at 350 pounds. R26's low air-loss pump had a dial, above the dial documented set by weight, the dial was set in 30-pound intervals. (Air Force 1000). (continued on next page)

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	175180	A. Building B. Wing	09/11/2024

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/11/24 at 01:06 PM, Certified Nurse's Aide (CNA)M stated central supply installs all mattresses, and nursing checks mattresses to ensure they are set at the correct weight. He stated all staff can check the mattress to ensure the bed is plugged in. On 09/11/24 at 01:19 PM, Administrative Nurse E stated nursing was to check the mattress to ensure the mattress was working. She stated the low air loss mattresses were set by weight. On 09/11/24 at 02:09 PM, Administrative Nurse D stated central supply installed all the low air loss mattresses. She stated central supply sets the mattress to the correct weight. Administrative Nurse D stated nursing staff was to ensure the bed and mattress were working correctly. The facility did not provide a low air loss mattress policy. The facility failed to ensure R26's low air loss mattress was plugged in and further failed to set it at the correct weight to provide adequate pressure relief. This placed R26 at increased risk for pressure ulcer development.

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	175180	A. Building B. Wing	09/11/2024

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634 The facility identified a census of 87 residents. The sample included 20 residents with four residents reviewed for positioning and mobility. Based on observation, record review, and interviews, the facility failed to ensure Resident (R)26, R50, and R9 were provided the services and treatment to prevent worsening of contractures (abnormal permanent fixation of a joint or muscle). This deficient practice placed the residents at risk for discomfort and decreased range of motion (ROM- the full movement potential of a joint, usually its range of flexion and extension). Findings included: - R26's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of lack of coordination, restlessness and agitation, hypertension (HTN-elevated blood pressure), depression (a mood disorder that causes a persistent depression feeling of sadness and loss of interest), dysphagia (swallowing difficulty), weakness, pseudobulbar affect (a neurological condition that causes people to experience uncontrolled and inappropriate laughing or crying), abnormal weight loss, and Huntington's disease (a rare abnormal hereditary condition characterized by progressive mental deterioration, a disabling central nervous system movement disorder). The Quarterly Minimum Data Set (MDS) dated 06//14/24 R26 documented a Brief Interview of Mental Status (BIMS) score of three which indicated severely impaired cognition. The MDS documented R26 was dependent on staff for eating and required substantial to maximal assistance for all activities of daily living (ADLs). The MDS indicated that R26 was not receiving restorative treatment during the observation period. R26's Falls Care Area Assessment (CAA) dated 12/14/23 documented R26 had impaired gait and mobility, and contributing factors included weakness. R26's Care Plan revised 01/15/24 documented that R26 would have no complications related to immobility, including contractures. R26's plan of care dated 01/09/24 documented staff to maintain R26's range of motion, and decreased range of motion was anticipated related to Huntington's disease. The plan of care documented nursing was to address and provide a plan of care for rehabilitation and restorative plan to the resident and representative. R26's plan of care stated nursing would provide passive range of motion with care. A review of R26's EMR under Task from 08/11/24 through 09/09/24 lacked documentation that range of motion was provided for R26's hands. On 09/09/24 at 09:14 AM R26 sat in the dining room in her Broda chair (specialized wheelchair with the ability to tilt and recline). R26's hands laid in her lap curled at the wrist and hands closed. On 9/10/24 at 10:55 AM R26 lay reclined in her Broda chair in the commons area with peers. R26's hands were curled at the wrist and closed into fists. Her right hand was on her lap and her left arm was bent with her fist to her chest. (continued on next page)

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	175180	A. Building B. Wing	09/11/2024

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/11/24 at 09:18 AM, Consultant GG stated the facility does not have a restorative program. She stated therapy did some resident-led programs and education for staff. She stated the facility was working on getting a person in place for the restorative program. On 09/11/24 at 01:06 PM, Certified Nurse's Aide (CNA) M stated the facility did not have a restorative program. He stated he doesn't know about the other CNAs, but he does do some range of motion with the residents when he works. He stated range of motion, if it was being done, was not charted anywhere. On 09/11/24 at 01:19 PM Administrative Nurse E stated the facility did not have anyone doing range of motion or restorative treatments. She stated she was unsure if there was a place to document when range of motion was performed. On 09/11/24 at 02:24 PM, Administrative Nurse D stated the facility assessed each resident for decline. Administrative Nurse D stated the facility did not have a restorative program, and stated physical therapy assessed each resident every quarter. She said if staff noted a decline, staff would get a doctor's order to treat, and if the resident didn't qualify for therapy the facility would give them four free days. The facility did not provide a restorative program policy. The facility failed to ensure R26 received services and treatment for her contractures to prevent further loss of ROM and to promote comfort. This deficient practice left R26 at risk for further decline and discomfort. 45668 - The Medical Diagnosis section within R50's Electronic Medical Records (EMR) noted diagnoses of cerebral infarction (stroke - the 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), muscle weakness, cognitive-communication deficit, morbid obesity (severely overweight), and hemiparesis/hemiplegia (weakness and paralysis on one side of the body). R50's Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 13 indicating no cognitive impairment. The MDS indicated she had no upper or lower extremity impairments. The MDS indicated she was dependent on staff for transfers, bed mobility, dressing, toileting, personal hygiene, and ambulation with her wheelchair. The MDS indicated she received no restorative services. R50's Functional Abilities Care Area Assessment (CAA) completed 07/029/24 indicated she had left-sided hemiplegia due to her recent stroke. The CAA noted she was dependent on staff for toileting, bathing, dressing, bed mobility, and transfers. The CAA noted she required a Hoyer lift (total body mechanical lift) for transfers. The CAA indicated a care plan will be updated to address all areas of concern. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R50's Care Plan initiated on 08/03/20 indicated she was at risk for a decline in her activities of daily living (ADLs) related to her medical diagnoses. The plan indicated she was dependent on staff for bathing, bed mobility, dressing, personal hygiene, toileting, and transfers (08/03/20). The plan indicated she was at risk for decreased range of motion (04/27/21). The plan indicated a restorative program would address and provide a rehab/restorative plan for R50. The plan indicated R50 would receive active and passive ROM per therapy or nursing assessments (04/27/21). The plan indicated physical and occupational therapy will evaluate and treat per her orders (04/27/21). R50's EMR under Evaluations revealed a Rehab Screening completed on 07/25/24 that reported R50 had decreased participation in care and was not getting out of her bed. The note indicated a change that might require therapy intervention. The report noted R50 required increased assistance during daily care. The report indicated she had no restorative nurse program. R50's EMR revealed no newer therapy evaluations were completed after 07/25/24. R50's EMR under Progress Notes revealed a note completed on 07/26/24. The note indicated R50 requested to stay at the facility to have more physical and occupational therapy while in the facility. R50's EMR under Tasks revealed no passive or active range of motion activities. R50's EMR under Treatment Administration Report (TAR) for August and September of 2024 revealed no passive or active range of motion exercises listed or documented. R50's EMR under Progress Notes revealed no monitored or offered range of motion exercises for R50. On 09/09/24 at 08:20 AM R50 lay in her bed. She reported that she had been waiting to start therapy services for the last month. She stated the facility was not assisting her with maintaining her range of motion, strength, or ADL abilities. She stated the facility gave her a list of self-led activities she could do herself each day. She had left-sided weakness from a stroke and felt like the facility was not assisting her with maintaining her abilities. She stated the facility was not assisting or monitoring her while she was supposed to exercise. An inspection of R50's room revealed an exercise sheet on the wall in front of her bed. The sheet noted self-led exercises of leg lifts, arm stretches, and a pressure ball. She stated she had difficulty with the exercises due to her left-sided weakness and size. On 09/11/24 at 09:18 AM, Consultant GG stated the facility does not have a restorative program. She stated therapy did some resident-led programs and education for staff. She stated the facility was working on getting a person in place for the restorative program. She stated R50 had self-led exercises. Consultant GG stated staff does not assist R50 with her exercises. She stated R50 would verbally report her progress. Consultant GG stated she was not sure if staff monitored and documented R50's progress or how many times R50 completed the exercises. Consultant GG stated R50 was on the list to begin therapy services within a few weeks. On 09/11/24 at 01:06 PM, Certified Nurse's Aide (CNA) M stated the facility did not provide restorative service to the residents. He stated some of the residents had daily exercises but most of them were self-led. He stated he was not sure staff documented the daily exercises completed by the residents. (continued on next page)

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	175180	A. Building B. Wing	09/11/2024

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/11/24 at 02:20 PM Administrative Nurse D stated R50 completed self-led exercises but staff do not monitor her or document how often or if she completed them. She stated that R50 was independent with her exercises and would report to staff what she did. She stated the facility currently didn't have a restorative program and therapy was trying to put one in place. The facility did not provide a policy related to restorative care or range of motion as requested. The facility failed to provide services to maintain or improve R50's range of motion and ADL abilities while waiting for her therapy services to begin. This placed R50 at risk for a decline in her range of motion and developing contractures. 41713 - R9's Electronic Medical Record (EMR) documented diagnoses of multiple sclerosis (MS- progressive disease of the nerve fibers of the brain and spinal cord), and contracture (abnormal permanent fixation of a joint or muscle) of the right hand. R9's Annual Minimum Data Set (MDS) dated [DATE] documented R9 had both long and short-term memory problems. R9 had impairment on one side of both upper and lower extremities. R9 was independent with eating but relied on staff for all other activities of daily living (ADLs). R9's Quarterly MDS dated [DATE] 09/23/23 documented R9 had both long and short-term memory problems. R9 had impairment on one side of both upper and lower extremities. R9 was independent with eating but relied on staff for all other ADLs. R9's Falls Care Area Assessment (CAA) dated 09/25/23 documented R9 was a maximum assist with transfers. R9 was only able to stand and pivot with maximal assist. R9's Care Plan revised on 02/06/24 directed staff to converse with R9 while providing care. The staff was directed to administer medications as directed. R9's Care Plan lacked staff direction for any restorative measures or direction regarding R9's palm guard splint. R9's Orders tab of the EMR documented an order dated 01/19/24 for a palm guard splint to the right hand to be applied daily for five to eight hours to reduce digit (finger) contracture. R9's September 2024 Treatment Administration Record (TAR) ordered to don (apply) the palm guard splint daily at 10:00 AM and revealed the splint had not been applied on 09/03/24, 09/04/24, 09/05/24, or 09/09/24 as the splint was not available. On 09/09/24 at 12:22 PM, R9 sat in her wheelchair at the dining table. R9 was not wearing her palm splint. On 09/10/24 at 02:26 PM, R9 sat in her wheelchair in her room with her right hand up close to her head. There was no splint on her hands. On 09/11/2 at 09:15 AM Licensed Nurse (LN) H stated she could not say why R9's splint was not on, where it was at, or why it had not been available. (continued on next page)

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	175180	A. Building B. Wing	09/11/2024

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/11/24 at 12:25 PM Administrative Nurse D stated R9 was not on any type of restorative program and had not received any physical therapy or occupational therapy for some time. Administrative Nurse D stated the facility currently did not have a restorative program. Administrative Nurse D stated that the nurse who worked those days had been agency staff and might not have known about R9's splint or where it was located. Administrative Nurse D stated she would educate the agency staff to ensure R9's palm splint was applied daily. The facility lacked a policy for splint use or restorative services as requested. The facility failed to ensure that staff applied R9's palm guard splint as ordered. This placed R9 at risk for decreased mobility and impaired quality of life.

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	175180	A. Building B. Wing	09/11/2024

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45668 The facility identified a census of 87 residents. The sample included 20 residents with one sampled resident reviewed for dialysis (a procedure where impurities or wastes were removed from the blood). Based on observation, record review, and interview, the facility failed to ensure ongoing communication and collaboration with the dialysis facility for dialysis care and services regarding Resident (R) 67's health status with each procedure. The facility additionally failed to weigh R67 before his dialysis appointments on eight occasions. This deficient practice placed R67 at risk for complications related to end-stage renal failure. Findings Included: - The Medical Diagnosis section within R67's Electronic Medical Records (EMR) noted diagnoses of major depressive disorder (major mood disorder), end-stage renal failure, and muscle weakness. R67's Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of five indicating severe cognitive impairment. The MDS indicated no upper or lower extremity impairments. The MDS indicated he required substantial to maximal assistance with toileting, bed mobility, dressing, bathing, and transfers. The MDS indicated he received dialysis services. R67's Functional Abilities Care Area Assessment (CAA) completed 02/13/24 indicated he required assistance with his activities of daily living (ADLs). The CAA indicated he was at risk for a decline in his ADLs, falls, nutritional impairment, and skin breakdown. R67's Care Plan initiated 06/09/22 indicated he needed hemodialysis related to his medical diagnoses. The plan indicated staff was to encourage him to attend his dialysis services. The plan noted he received dialysis services on Tuesdays, Thursdays, and Saturdays at 03:00 PM. R67's EMR under Physician's Orders revealed an order dated 06/29/24 for him to receive dialysis on Tuesday, Thursday, and Saturday at 11:00 AM. The order indicated staff was to weigh him before his dialysis appointment. An inspection of R37's dialysis communication binder revealed no weights were attained before his appointment on 09/03/24, 08/31/24, 08/20/24, 08/17/24, 08/12/24, 07/16/24, 07/25/24, and 07/18/24. The inspection also revealed the dialysis center communication section was not filled out on 08/31/224, 08/29/24, 08/24/24, 08/17/24, 08/10/24 08/03/24, 07/27/24, and 07/06/24. R37's EMR lacked weights documented for the list dates. On 09/10/24 at 09:30 AM R37 was weighed and assessed before his scheduled dialysis appointment. R37 attended his dialysis appointment without issue. (continued on next page)

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	175180	A. Building B. Wing	09/11/2024

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/11/24 at 01:06 PM Certified Nurse Aide (CNA) M stated R37 went to dialysis three times a week. He stated R37 was weighed before each appointment and documented in the EMR. He stated R37 takes the binder with him and brings it back upon return to the facility. He stated staff should make sure the full communication sheet was filled out when he returned to the facility. He stated staff was responsible for calling the dialysis center if the sheet was not completed. He stated refusals or missed appointments would be noted in the EMR or on the dialysis sheets. On 09/11/24 at 02:24 PM Administrative Nurse D stated it was the staff's responsibility to ensure the weights were being completed and the communication sheets were being filled out. She stated the assigned nurse or direct care staff should call the clinic and request the information be sent over if not completed on the communication sheet. The facility's Hemodialysis policy dated 02/2023 indicated the facility will coordinate with the dialysis center to ensure ongoing communication and relay information related to care needs. The policy indicates the facility will closely monitor changes in appetite, weight, labs, and function abilities before and after dialysis services are provided. The facility failed to ensure ongoing communication and collaboration with the dialysis facility regarding R67's health status with each procedure. The facility additionally failed to weigh R67 before his dialysis appointments on eight occasions. This deficient practice placed R67 at risk for complications related to end-stage renal failure.

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	175180	A. Building B. Wing	09/11/2024

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45668 The facility identified a census of 87 residents. The sample included 20 residents with two residents reviewed for accidents. Based on observation, record review, and interviews, the facility failed to ensure that Resident (R)37 had a safety assessment for the use of side rails, consent for the use of the side rails, and failed to ensure the resident and/or responsible party were advised of the risks and/or benefits of the use of the side rails. This placed R37 at risk for uninformed decisions and impaired safety related to the risks associated with the use of side rails. Findings Included: - The Medical Diagnosis section within R37's Electronic Medical Records (EMR) noted diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), and Parkinsonism (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness). R37's Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of five indicating severe cognitive impairment. The MDS indicated he had upper and lower extremity impairments. The MDS indicated he was dependent on staff assistance for oral hygiene, bed mobility, toileting, bathing, dressing, and transfers. The MDS indicated he had no side rails. R37's Functional Abilities Care Area Assessment (CAA) completed 01/03/24 indicated he required assistance with his activities of daily living (ADLs) related to his generalized weakness, decreased safety awareness, and medical diagnoses. The CAA indicated other risk factors for R37 including urinary incontinence, skin breakdown, falls, and pressure ulcers. R37's Care Plan initiated 03/09/22 indicated he required partial to moderate assistance with bed mobility, dressing, personal hygiene, toileting, bathing, and transfers. The plan identified he had a low air-loss mattress but lacked documentation of his bilateral bed cane-style side rails. R37's EMR under Physician Orders lacked documentation related to his bed canes. R37's EMR on 09/10/24 lacked a documented safety assessment for the use of side rails, and consent for the use of the side rails. The EMR lacked evidence the resident and/or responsible party were advised of the risks and/or benefits of the use of the side rails. On 09/11/24 at 10:20 AM Administrative Staff A provided a Nursing Entrapment Risk Assessment for R37 was completed on 09/11/24. The assessment indicated R37 had side rails used for mobility. The assessment failed to identify R37's risks associated with his low air-loss mattress. A review of the low air-loss mattress manufacturer's operation (Drive Model #14027) manual indicated the usage of bed rails with the air mattress system should be assessed based on the risk of entrapment. (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	09/11/2024

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

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/09/24 at 07:23 AM an inspection of R37's room revealed a bordered mattress and bed cane (a side rail device attached to the bed to improve bed mobility) on both sides of his bed. R37's bed had a Drive Model low air-loss mattress system set at 350 pounds (lbs.). On 09/11/24 at 01:06 PM Certified Nurse's Aide (CNA) M stated staff inspected the beds each shift to ensure no gaps were present between the mattress and the railing. On 09/11/24 at 01:19 PM Administrative Nurse E stated the bed rails were inspected quarterly but was not sure where it was documented. She stated the side rail assessment should include the type of mattress and possible risks associated with the use of the rails. On 09/11/24 at 02:24 PM Administrative Nurse D stated the bed rails should be inspected quarterly but was unable to find the previous company's assessments for the railing. She provided the assessment completed on 09/11/24. The facility's Bed Safety and Bed Rails policy 08/2022 indicated the facility must assess the resident's environment, medical conditions, functional abilities, and safety risks before implementing bed rails. The facility failed to ensure that R37 had a safety assessment for the use of side rails that acknowledged the risks from the low air-loss mattress, a consent for the use of the side rails, and failed to ensure the resident and/or responsible party were advised of the risks and/or benefits of the use of the side rails. This placed R37 at risk for uninformed decisions and impaired safety related to the risks associated with the use of side rails.

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	175180	A. Building B. Wing	09/11/2024

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41713 The facility identified a census of 87 residents. The sample included 20 residents with five sampled residents reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to ensure a medication regimen review (MRR) was completed at least monthly for Resident (R) 31, R79, R28, R39, and R50. The facility further failed to ensure the Consultant Pharmacist (CP) identified and made recommendations for a Center for Medicaid and Medicare (CMS) approved indication or a gradual dose reduction (GDR) for antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medications for R31 and R28. The facility failed to ensure the CP identified and reported R79 and R28's diclofenac (Voltaren- a topical medication that reduces pain and inflammation) lacked a dosage. The facility failed to ensure the CP identified and reported R39's antihypertensive (a class of medication used to treat high blood pressure) medication was given outside of the physician-ordered parameters. These failures placed the resident at risk for unnecessary medication effects. Findings included: - On 09/11/24 the facility was unable to provide the CP's MRRs from October 2023 to December 2023 for R31, R79, R28, R39, and R50. Review the Electronic Medical Record (EMR) for R31, R79, R28, R39, and R50 lacked evidence the MRR was completed from October 2023 through December 2023. On 09/2/24 at 02:25 PM Administrative Nurse D verified the facility was not able to locate the CP recommendations from October 2023 to December 2023. Administrative Nurse D stated she could not say what the previous owners and their staff might have done with those recommendations. The undated Medication Regimen Reviews policy documented that the CP would perform a medication MRR for every resident in the facility. The primary purpose of this review was to help the facility maintain each resident's highest practicable level of functioning by helping them utilize medications appropriately and prevent or minimize adverse consequences related to medication therapy to the extent possible. The facility failed to ensure an MRR was completed at least monthly. This placed the affected residents at risk for unnecessary medications and related complications. - R31's Electronic Medical Record (EMR) documented diagnosis of hypertension (HTN- elevated blood pressure), delusional disorders (untrue persistent belief or perception held by a person although evidence shows it was untrue), and vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain). (continued on next page)

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	175180	A. Building B. Wing	09/11/2024

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R31's Annual Minimum Data Set (MDS) dated [DATE] documented that R31 had both long and short-term memory problems. R31 had severely impaired cognitive skills for daily decision-making. R31 was dependent on staff for her activities of daily living (ADLs). R31 used a wheelchair for mobility that staff propelled. R31 routinely received an antipsychotic medication. A GDR had not been attempted or documented by the physician as clinically contraindicated. R31's Psychotropic Drug Use Care Area Assessment (CAA) dated 09/09/24 lacked any documented analysis. R31's Care Plan last revised 08/19/24, directed staff to administer psychotropic medications as directed. Staff was directed to monitor R31 for behaviors such as being verbally inappropriate, hallucinations (sensing things while awake that appear to be real, but the mind created), or delusions. R31's 11/17/22 Psychiatric Initial Assessment documented her delusional disorder and vascular dementia was being treated with Seroquel. R31 was currently stable on the medication and was to continue the medication. R31's Order Summary Report documented an order dated 12/04/23 for Seroquel (an antipsychotic medication) 25 milligrams (mg) to give one tablet by mouth twice daily for vascular dementia. A review of R31's MRR from January 2024 to July 2024 lacked evidence the CP identified and recommended a CMS-approved indication and a GDR for Seroquel use. R31's clinical records lacked a physician's documented clinical rationale for the continued use of Seroquel without a GDR or approved indication for use. On 09/10/24 at 09:22 AM, R31 sat in her wheelchair at the dining table with other residents. R31 displayed no behaviors. On 09/11/24 at 01:18 PM, Administrative Nurse E stated that she had not done anything with the CP recommendations yet. On 09/2/24 at 02:25 PM Administrative Nurse D stated she and the CP had been working with the physicians to attempt to decrease the use of Seroquel and to ensure that an appropriate indication for use, and the risk versus benefit for the use of Seroquel was completed as well as a GDR. (continued on next page)

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	175180	A. Building B. Wing	09/11/2024

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The undated Medication Regimen Reviews policy documented that the CP would perform a medication MRR for every resident in the facility. The primary purpose of this review was to help the facility maintain each resident's highest practicable level of functioning by helping them utilize medications appropriately and prevent or minimize adverse consequences related to medication therapy to the extent possible. As part of the MRR, the CP would: Evaluate whether any medications in a drug regimen present potentially significant drug-drug or drug-food interactions; Determine if the resident was receiving the correct medications as ordered; Determine if medications were administered at the prescribed times; Determine if medications were administered in the correct dosage and form; Be alert to medications with potentially significant medication-related adverse consequences and to actual signs and symptoms that could represent adverse consequences; and Identify medication errors, including those related to documentation. The CP would document his/her findings and recommendations on the monthly drug/medication regimen review report. The CP would provide a written report to physicians for each resident with an identified irregularity. The CP would provide the Director of Nursing Services and Medical Director with a written, signed, and dated copy of the report, listing the irregularities found and recommendations for their solutions. Copies of drug/medication regimen review reports, including physician responses, would be maintained as part of the permanent medical record. The facility failed to ensure the CP identified and reported that R31 lacked a CMS-approved indication or the required physician documentation, for use for antipsychotic medications without GDR attempts. This placed R31 at risk for unnecessary medication administration and possible adverse side effects. - R79's Electronic Medical Record (EMR) documented diagnoses of hallucinations (sensing things while awake that appear to be real, but the mind created), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), Lewy body dementia (a progressive disorder that results from protein deposits in nerve cells of the brain affecting movement, thinking skills, mood, memory, and behavior), and Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness). R79's Admission Minimum Data Set (MDS) dated [DATE] documented he had both short and long-term memory problems. R79 had severely impaired cognitive skills for daily decision-making. R79 displayed disorganized thinking that fluctuated. R79 displayed behaviors of hallucinations. R79 required supervision for activities of daily living (ADLs). R79 received antipsychotic medications on a routine basis. A GDR had not been attempted on R79's medications. R79's Quarterly MDS dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of three which indicated severely impaired cognition. R79 was dependent on staff for all functional abilities and care. R79 received antipsychotic medications on a routine basis. A GDR had not been attempted on R79's medications. R79's Psychotropic Drug Use Care Area Assessment (CAA) dated 12/28/23 documented he used psychotropic medications to manage psychiatric illnesses. A licensed nurse would monitor R79 for medication side effects each shift. A pharmacist consultant would review R79's medications monthly and the physician would review medications with each visit. R79's Care Plan last revised 02/27/24 directed staff to administer psychotropic medications as ordered. Staff was directed to document all behaviors and evaluate the side effects of the medications. (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	09/11/2024

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R79's Order Summary Report from 12/15/23 to 09/11/24 documented an order dated 12/15/23 for Seroquel (an antipsychotic medication) 12.5 milligrams (mg) one time a day for hallucinations. R79's Order Summary Report from 12/15/23 to 09/11/24 documented an order dated 02/15/24 for Seroquel 12.5 mg one time a day for agitation and hallucinations. R79's Order Summary Report from 12/15/23 to 09/11/24 documented an order dated 03/22/24 for Seroquel 50 (mg) one time a day for agitation and hallucination. R79's Order Summary Report from 12/15/23 to 09/10/24 documented an order dated 12/15/23 for diclofenac (Voltaren) gel to apply to knees topically four times a day related to arthritis. A review of R79's MRR from January 2024 to the present revealed the lack of a CP recommendation for a CMS-approved indication for use for Seroquel or a recommended GDR. R79's clinical records lacked a physician's documented clinical rationale for the continued use of Seroquel without a GDR or approved indication for use. The facility was unable to provide this information upon request. On 09/10/24 at 12:45 PM, R79 paced about the Serenity unit with a staff member. On 09/11/24 at 01:18 PM, Administrative Nurse E stated that she had not done anything with the CP recommendations yet. On 09/2/24 at 02:25 PM Administrative Nurse D stated the facility was not able to locate the CP recommendations from October 2023 to December 2023. Administrative Nurse D could not say what the previous owners and their staff might have done with those recommendations. Administrative Nurse D stated she and the CP had been working with the physicians to attempt to decrease the use of Seroquel unless contraindicated and ensure that an appropriate indication for use, and the risk versus benefit for the use of Seroquel was completed as well as a GDR. The undated Medication Regimen Reviews policy documented that the CP would perform a medication MRR for every resident in the facility. The primary purpose of this review was to help the facility maintain each resident's highest practicable level of functioning by helping them utilize medications appropriately and prevent or minimize adverse consequences related to medication therapy to the extent possible. As part of the MRR, the CP would: Evaluate whether any medications in a drug regimen present potentially significant drug-drug or drug-food interactions; Determine if the resident was receiving the correct medications as ordered; Determine if medications were administered at the prescribed times; Determine if medications were administered in the correct dosage and form; Be alert to medications with potentially significant medication-related adverse consequences and to actual signs and symptoms that could represent adverse consequences; and Identify medication errors, including those related to documentation. The CP would document his/her findings and recommendations on the monthly drug/medication regimen review report. The CP would provide a written report to physicians for each resident with an identified irregularity. The CP would provide the Director of Nursing Services and Medical Director with a written, signed, and dated copy of the report, listing the irregularities found and recommendations for their solutions. Copies of drug/medication regimen review reports, including physician responses, would be maintained as part of the permanent medical record. (continued on next page)

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	175180	A. Building B. Wing	09/11/2024

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility failed to ensure the CP idenitfied and reported the lack of a CMS-approved indication or the required physician documentation, for use for antipsychotic medications without GDR attempts and failed to identify and report the lack of dosing instructions for Voltaren. This placed R79 at risk for unnecessary medication administration and possible adverse side effects. 41037 - R28's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and psychosis (any major mental disorder characterized by gross impairment in reality perception). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R28 received antianxiety (a class of medications that calm and relax people) medication, anticoagulant (a class of medications used to prevent the blood from clotting) medication, and antipsychotic medication. The Quarterly MDS dated [DATE] documented a BIMS score of 15 which indicated intact cognition. The MDS documented R28 received antianxiety medication, anticoagulant medication, and antipsychotic medication. R28's Psychotropic Drug Use Care Area Assessment (CAA) dated 05/20/24 lacked documentation of or analysis of the triggered CAA. R28's Care Plan dated 01/24/24 documented the staff would administer medication as ordered. R28's EMR under the Orders tab revealed the following physician orders: Diclofenac sodium (Voltaren-non-steroidal anti-inflammatory drug [NSAID]) external gel one percent (%) apply to affected area(s) topically two times a day for pain dated 04/23/24. The order lacked a dosing instruction. Quetiapine fumarate (antipsychotic) oral tablet 50 milligrams (mg) give one tablet by mouth three times a day related to anxiety disorder dated 01/18/24. A review of R28's Monthly Medication Review (MMR) from January 2024 through July 2024 lacked evidence the CP identified and reported the lack of dosing instructions for Voltaren. The MMRs also lacked a recommendation to the physician for a gradual dose reduction or an approved Center for Medicare and Medicaid Services (CMS) indication. On 09/10/24 at 09:09 AM R28 sat in his wheelchair in the dining room as he watched videos on his cell phone. On 09/11/24 at 01:23 PM, Administrative Nurse E stated every medication order including Voltaren should have dosing instructions. She stated the nurse should call and clarify the order if it lacked dosing instructions. She stated she expected the consultant pharmacist to notify the facility regarding missing dosing instructions on the resident's monthly medication review. (continued on next page)

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	175180	A. Building B. Wing	09/11/2024

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/11/24 at 02:25 PM, Administrative Nurse D stated she expected all medication orders would have dosing instructions to be administered included on the order, including Voltaren. Administrative Nurse D stated she had been working with CP regarding the facility's expectations since May 2024. The facility's Medication Regimen Reviews (MRR) policy last revised 04/2007 documented the Consultant Pharmacist would review the medication regimen of each resident at least monthly. The primary purpose of this review was to help the facility maintain each resident's highest practicable level of functioning by helping them utilize medications appropriately and prevent or minimize adverse consequences related to medication therapy to the extent possible. As part of the MRR, the CP would: determine if the resident was receiving the correct medications as ordered, are administered in the correct dosage and form. The CP would document his/her findings and recommendations on the monthly drug/medication regimen review report. Copies of drug/medication regimen review reports, including physician responses, would be maintained as part of the permanent medical record. The facility failed to ensure the CP identified and reported irregularities for a lack of dosing instructions for Voltaren gel and further failed to identify and recommend a GDR and a CMS-approved indication for R28's quetiapine. This deficient practice placed R28 at risk for unnecessary medication use, side effects, and physical complications. - R39's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), atrial fibrillation (rapid, irregular heartbeat), hypertension (HTN-elevated blood pressure), and sleep apnea (a disorder of sleep characterized by periods without respirations). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 14 which indicated intact cognition. The MDS lacked documentation a monthly regimen review was completed during the observation period. The Quarterly MDS dated [DATE] documented a BIMS score of 14 which indicated intact cognition. The MDS lacked documentation a monthly regimen review was completed during the observation period. R39's Psychotropic Drug Use Care Area Assessment (CAA) dated 05/30/24 documented he was at an increased risk of adverse side effects and that staff would continue to monitor for adverse reactions to his medications. R39's Care Plan dated 12/27/23 documented staff would administer cardiac medication as ordered and monitor for side effects. The plan of care documented that staff would notify the physician of adverse reactions as needed. R39's EMR under the Orders tab revealed the following physician orders: Carvedilol (medication used to treat high blood pressure) tablet 12.5 milligrams (mg) give one tablet by mouth two times a day for HTN. Hold if systolic blood pressure (SBP-relating to the phase of the heartbeat when the heart muscle contracts and pumps blood from the chambers into the arteries) was less than (<) 110 millimeters of mercury (mmHg). Hold if heart rate < 60 beats per minute. Use right arm only dated 06/19/24. (continued on next page)

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	175180	A. Building B. Wing	09/11/2024

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Torsemide (diuretic) tablet 20mg give one tablet by mouth in the morning for HTN Hold if SBP <110 mmHg or heart rate <60 beats dated 06/20/24. A review of R39's Medication Administration Record (MAR) from 06/01/24 to 09/09/24 (101 days) revealed Torsemide was given outside of the physician-ordered parameters on the following dates 06/20/24, 07/06/24, and 07/20/24. Carvedilol was given outside of the physician-ordered parameters on the following dates 06/22/24, 06/24/24, 06/27/24, 07/01/24, 07/02/24, 07/06/24, 07/20/24, 07/25/24, and 08/21/24. A review of R39's Monthly Medication Review (MMR) from January 2024 through July 2024 lacked evidence the CP identified and reported the antihypertensive and diuretic medication was administered outside the physician-ordered parameters. On 09/10/24 at 03:11 PM, R39 laid flat on his bed with his continuous positive airway pressure (CPAP-ventilation device that blows a gentle stream of air into the nose to keep the airway open during sleep) on as he slept. On 09/11/24 at 01:23 PM, Administrative Nurse E stated every medication order should be administered as ordered. She stated if the blood pressure or heart rate was outside the physician-ordered parameters the medication should be held, and the physician should be notified. On 09/11/24 at 02:25 PM, Administrative Nurse D stated she expected all medications should be given as the physician had ordered. Administrative Nurse D stated she had been working with CP regarding the facility's expectations since May 2024. The facility's Medication Regimen Reviews (MRR) policy last revised 04/2007 documented the Consultant Pharmacist would review the medication regimen of each resident at least monthly. The primary purpose of this review was to help the facility maintain each resident's highest practicable level of functioning by helping them utilize medications appropriately and prevent or minimize adverse consequences related to medication therapy to the extent possible. As part of the MRR, the CP would: determine if the resident was receiving the correct medications as ordered, are administered in the correct dosage and form. The CP would document his/her findings and recommendations on the monthly drug/medication regimen review report. Copies of drug/medication regimen review reports, including physician responses, would be maintained as part of the permanent medical record. The facility failed to ensure the CP identified and reported irregularities for medications given outside the physician-ordered parameters for R39. This deficient practice placed R39 at risk for unnecessary medication use, side effects, and physical complications.

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	175180	A. Building B. Wing	09/11/2024

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037 The facility identified a census of 87 residents. The sample included 20 residents with five residents reviewed for unnecessary medications. Based on observation, record review, and interviews, the facility failed to ensure antihypertensive (medication used to treat high blood pressure) medication was administered per the physician-ordered parameters for Resident (R) 39 and the facility further failed to ensure dosing instructions for Voltaren (non-steroidal anti-inflammatory drug [NSAID]) for R28 and R79. These deficient practices placed these residents at risk for unnecessary medication use, side effects, and physical complications. Findings included: - R39's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), atrial fibrillation (rapid, irregular heartbeat), hypertension (HTN-elevated blood pressure), and sleep apnea (a disorder of sleep characterized by periods without respirations). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 14 which indicated intact cognition. The MDS lacked documentation a monthly regimen review was completed during the observation period. The Quarterly MDS dated [DATE] documented a BIMS score of 14 which indicated intact cognition. The MDS lacked documentation a monthly regimen review was completed during the observation period. R39's Psychotropic Drug Use Care Area Assessment (CAA) dated 05/30/24 documented he was at an increased risk of adverse side effects and that staff would continue to monitor for adverse reactions to his medications. R39's Care Plan dated 12/27/23 documented staff would administer cardiac medication as ordered and monitor for side effects. The plan of care documented that staff would notify the physician of adverse reactions as needed. R39's EMR under the Orders tab revealed the following physician orders: Carvedilol (medication used to treat high blood pressure) tablet 12.5 milligrams (mg) give one tablet by mouth two times a day for HTN. Hold if systolic blood pressure (SBP-relating to the phase of the heartbeat when the heart muscle contracts and pumps blood from the chambers into the arteries) was less than (<) 110 millimeters of mercury (mmHg). Hold if heart rate < 60 beats per minute. Use right arm only dated 06/19/24. Torsemide (diuretic) tablet 20mg give one tablet by mouth in the morning for HTN Hold if SBP <110 mmHg or heart rate <60 beats dated 06/20/24. (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	09/11/2024

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

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R39's Medication Administration Record (MAR) from 06/01/24 to 09/09/24 (101 days) revealed Torsemide was given outside of the physician-ordered parameters on the following dates 06/20/24, 07/06/24, and 07/20/24. Carvedilol was given outside of the physician-ordered parameters on the following dates 06/22/24, 06/24/24, 06/27/24, 07/01/24, 07/02/24, 07/06/24, 07/20/24, 07/25/24, and 08/21/24. On 09/10/24 at 03:11 PM, R39 laid flat on his bed with his continuous positive airway pressure (CPAP-ventilation device that blows a gentle stream of air into the nose to keep the airway open during sleep) on as he slept. On 09/11/24 at 01:23 PM, Administrative Nurse E stated every medication order should be administered as ordered. She stated if the blood pressure or heart rate was outside the physician-ordered parameters the medication should be held, and the physician should be notified. On 09/11/24 at 02:25 PM, Administrative Nurse D stated she expected all medications should be given as the physician had ordered. The facility's Medication Orders policy last revised 11/2014 documented medication orders received and when recording orders for medication, specify the type, route, dosage, frequency, and strength of the medication ordered. A placebo is considered a medication and must also have specific orders. The facility failed to ensure staff followed physician orders for R39's antihypertensive medications. This deficient practice placed R39 at risk of adverse side effects and unnecessary medications related to hypertension. - R28's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and psychosis (any major mental disorder characterized by gross impairment in reality perception). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R28 received antianxiety (a class of medications that calm and relax people) medication, anticoagulant (a class of medications used to prevent the blood from clotting) medication and antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication. The Quarterly MDS dated [DATE] documented a BIMS score of 15 which indicated intact cognition. The MDS documented R28 received antianxiety medication, anticoagulant medication, and antipsychotic medication. R28's Psychotropic Drug Use Care Area Assessment (CAA) dated 05/20/24 lacked documentation of or analysis of the triggered CAA. R28's Care Plan dated 01/24/24 documented the staff would administer medication as ordered. R28's EMR under the Orders tab revealed the following physician orders: (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Diclofenac sodium (Voltaren-non-steroidal anti-inflammatory drug [NSAID]) external gel one percent (%) apply to affected area(s) topically two times a day for pain dated 04/23/24. The order lacked a dosing instruction. On 09/10/24 at 09:09 AM R28 sat in his wheelchair in the dining room as he watched videos on his cell phone. On 09/11/24 at 01:23 PM, Administrative Nurse E stated every medication order including Voltaren should have dosing instructions. She stated the nurse should call and clarify the order if it lacked dosing instructions. She stated she expected the consultant pharmacist to notify the facility regarding missing dosing instructions on the resident's monthly medication review. On 09/11/24 at 02:25 PM, Administrative Nurse D stated she expected all medication orders would have dosing instructions to be administered included on the order, including Voltaren. The facility's Medication Orders policy last revised 11/2014 documented medication orders received and when recording orders for medication, specify the type, route, dosage, frequency, and strength of the medication ordered. A placebo is considered a medication and must also have specific orders. The facility failed to ensure dosing instructions for Voltaren gel for R28. This deficient practice placed R28 at risk for unnecessary medication use, side effects, and physical complications. 41713 - R79's Electronic Medical Record (EMR) documented diagnoses of arthritis (inflammation of a joint characterized by pain, swelling, redness, and limitation of movement), hallucinations (sensing things while awake that appear to be real, but the mind created), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), Lewy body dementia (progressive disorder that results from protein deposits in nerve cells of brain affecting movement, thinking skills, mood, memory, and behavior), and Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness). R79's Admission Minimum Data Set (MDS) dated [DATE] documented he had both short and long-term memory problems. R79 had severely impaired cognitive skills for daily decision-making. R79 displayed disorganized thinking that fluctuated. R79 displayed behaviors of hallucinations. R79 required supervision for activities of daily living (ADLs). R79 received antipsychotic medications on a routine basis. A GDR had not been attempted on R79's medications. R79 was on hospice services. R79's Quarterly MDS dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of three which indicated severely impaired cognition. R79 was dependent on staff for all functional abilities and care. R79 received antipsychotic medications on a routine basis. A GDR had not been attempted on R79's medications. R79's Care Plan last revised 02/27/24 directed staff to administer medications as ordered. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R79's Order Summary Report from 12/15/23 to 09/10/24 documented an order dated 12/15/23 for diclofenac (Voltaren) gel applied to knees topically four times a day related to arthritis. This order lacked a physician's indicated dosage to apply. On 09/10/24 at 12:45 PM, R79 paced about the Serenity unit with a staff member. On 09/11/24 at 01:18 PM Administrative Nurse E stated all medication orders even for Voltaren should have an indicated dosage amount to apply. On 09/11/24 at 02:25 PM Administrative Nurse D stated that R79's Voltaren should have a dosage amount on the order. Administrative Nurse D stated R79's Voltaren order had been updated to indicate the amount to apply with each administration. The Medication Orders policy last revised in November 2014 documented: When recording orders for medications, specify the type, route, dosage, frequency, strength, and reason for administration. The facility failed to ensure R79's physician-ordered Voltaren had an indicated dosage for application. This placed R79 at risk of unnecessary medication administration and possible adverse side effects.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037 The facility identified a census of 87 residents. The sample included 20 residents with five residents reviewed for unnecessary medications. Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 28, R31, and R79 had a Center for Medicare and Medicaid Services (CMS) approved indication for the use of an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) or the required physician documentation. The facility further failed to ensure a gradual dose reduction (GDR) was attempted or documented as contraindicated by the physician with a supporting rationale. These deficient practices placed these residents at risk for unnecessary medications and adverse side effects. Findings included: - R28's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and psychosis (any major mental disorder characterized by gross impairment in reality perception). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R28 received antianxiety (a class of medications that calm and relax people) medication, anticoagulant (a class of medications used to prevent the blood from clotting) medication, and antipsychotic medication. The MDS documented no GDR was attempted and lacked documentation if a past GDR was attempted for R28. R28's MDS documented there was no physician documentation that clinically contraindicated a GDR. The MDS lacked documentation a monthly regimen review was completed during the observation period. The Quarterly MDS dated [DATE] documented a BIMS score of 15 which indicated intact cognition. The MDS documented R28 received antianxiety medication, anticoagulant medication, and antipsychotic medication. The MDS documented no GDR was attempted during the observation period and lacked documentation of a past GDR was attempted for R28. R28's MDS documented there was no physician documentation that clinically contraindicated a GDR. The MDS lacked documentation a monthly regimen review was completed during the observation period. R28's Psychotropic Drug Use Care Area Assessment (CAA) dated 05/20/24 lacked documentation of or analysis of the triggered CAA. R28's Care Plan dated 01/24/24 documented the staff would administer medication as ordered. R28's EMR under the Orders tab revealed the following physician orders: Quetiapine fumarate (Seroquel-antipsychotic) oral tablet 50 milligrams (mg) give one tablet by mouth three times a day related to anxiety disorder dated 01/18/24. (continued on next page)

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	175180	A. Building B. Wing	09/11/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R28's clinical record lacked physician documentation of a rationale for a non-approved CMS indication for the continued use of the antipsychotic medication Seroquel and for the continued use of psychotropic medication with no gradual dose reduction. The facility was unable to provide evidence of the above physician documentation. On 09/10/24 at 09:09 AM R28 sat in his wheelchair in the dining room as he watched videos on his cell phone. On 09/11/24 at 01:18 PM, Administrative Nurse E stated that mood was an appropriate indication for the use of an antipsychotic medication. Administrative Nurse E stated she was not that familiar with the GDR or the risk versus benefit rationale for R28's Seroquel use. On 09/2/24 at 02:25 PM Administrative Nurse D stated the facility had been working with the physicians to attempt to decrease the use of the Seroquel unless contraindicated. Administrative Nurse D stated the facility had been working with the physician to ensure that an appropriate indication for use, and the risk versus benefit for the use of Seroquel was completed. The Tapering Medications and Gradual Drug Dose Reduction last revised in July 2022 documented that residents who used psychotropic medications should receive a gradual dose reduction, unless clinically contraindicated, to discontinue the use of such drugs. Pertinent behavioral interventions (refer to non-pharmacological attempts to influence an individual's behavior, including environmental alterations and staff approaches to care) would be attempted. Within the first year after a resident was admitted on a psychotropic medication or after the resident has been started on a psychotropic medication, the staff and practitioner shall attempt a GDR in two separate quarters (with at least one month between the attempts), unless clinically contraindicated. After the first year, the facility shall attempt a GDR at least annually, unless clinically contraindicated. For any individual who was receiving a psychotropic medication to treat behavioral symptoms related to dementia, the GDR may be considered clinically contraindicated if: the resident's target symptoms returned or worsened after the most recent attempt at a GDR within the facility; and the physician has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or increase distressed behavior. For any individual who was receiving a psychotropic medication to treat a psychiatric disorder other than behavioral symptoms related to dementia, the GDR may be considered contraindicated, if: the continued use was in accordance with relevant current standards of practice and the physician has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying psychiatric disorder, or the resident's target symptoms returned or worsened after the most recent attempt at a GDR within the facility and the physician has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder. The facility failed to ensure R28 had a CMS-approved indication or the required physician documentation, for use for antipsychotic medications without GDR attempts. This placed R28 at risk for unnecessary medication administration and possible adverse side effects. 41713 (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- R31's Electronic Medical Record (EMR) documented diagnosis of hypertension (HTN- elevated blood pressure), delusional disorders (untrue persistent belief or perception held by a person although evidence shows it was untrue), and vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain). R31's Annual Minimum Data Set (MDS) dated [DATE] documented that R31 had both long and short-term memory problems. R31 had severely impaired cognitive skills for daily decision-making. R31 was dependent on staff for her activities of daily living (ADLs). R31 used a wheelchair for mobility that staff propelled. R31 routinely was administered an antipsychotic medication. A GDR had not been attempted or documented by the physician as clinically contraindicated. R31's Psychotropic Drug Use Care Area Assessment (CAA) dated 09/09/24 lacked any documented analysis. R31's Care Plan last revised 08/19/24, directed staff to administer psychotropic medications as directed. Staff was directed to monitor R31 for behaviors such as being verbally inappropriate, hallucinations (sensing things while awake that appear to be real, but the mind created), or delusions. R31's 11/17/22 Psychiatric Initial Assessment documented her delusional disorder and vascular dementia was being treated with Seroquel. R31 was currently stable on the medication and was to continue the medication. R31's Order Summary Report documented an order dated 12/04/23 for Seroquel (an antipsychotic medication) 25 milligrams (mg) to give one tablet by mouth twice daily for vascular dementia. R31's clinical records lacked a physician's documented clinical rationale for the continued use of Seroquel without a GDR or approved indication for use. The facility was unable to this information upon request. On 09/10/24 at 09:22 AM, R31 sat in her wheelchair at the dining table with other residents. R31 displayed no behaviors. On 09/11/24 at 01:18 PM, Administrative Nurse E stated that mood was an appropriate indication for the use of an antipsychotic medication. Administrative Nurse E stated she was not that familiar with the GDR or the risk versus benefit rationale for R31's Seroquel use. On 09/2/24 at 02:25 PM Administrative Nurse D stated the facility had been working with the physicians to attempt to decrease the use of the Seroquel unless contraindicated. Administrative Nurse D stated the facility had been working with the physician to ensure that an appropriate indication for use, and the risk versus benefit for the use of Seroquel was completed. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Tapering Medications and Gradual Drug Dose Reduction last revised in July 2022 documented that residents who used psychotropic medications should receive a gradual dose reduction, unless clinically contraindicated, to discontinue the use of such drugs. Pertinent behavioral interventions (refer to non-pharmacological attempts to influence an individual's behavior, including environmental alterations and staff approaches to care) would be attempted. Within the first year after a resident was admitted on a psychotropic medication or after the resident has been started on a psychotropic medication, the staff and practitioner shall attempt a GDR in two separate quarters (with at least one month between the attempts), unless clinically contraindicated. After the first year, the facility shall attempt a GDR at least annually, unless clinically contraindicated. For any individual who was receiving a psychotropic medication to treat behavioral symptoms related to dementia, the GDR may be considered clinically contraindicated if: the resident's target symptoms returned or worsened after the most recent attempt at a GDR within the facility; and the physician has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or increase distressed behavior. For any individual who was receiving a psychotropic medication to treat a psychiatric disorder other than behavioral symptoms related to dementia, the GDR may be considered contraindicated, if: the continued use was in accordance with relevant current standards of practice and the physician has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying psychiatric disorder, or the resident's target symptoms returned or worsened after the most recent attempt at a GDR within the facility and the physician has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder. The facility failed to ensure R31 had a CMS-approved indication or the required physician documentation, for continued use of antipsychotic medications without GDR attempts. This placed R131 at risk for unnecessary medication administration and possible adverse side effects. - R79's Electronic Medical Record (EMR) documented diagnoses of hallucinations (sensing things while awake that appear to be real, but the mind created), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), Lewy body dementia (a progressive disorder that results from protein deposits in nerve cells of the brain affecting movement, thinking skills, mood, memory, and behavior), and Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness). R79's Admission Minimum Data Set (MDS) dated [DATE] documented he had both short and long-term memory problems. R79 had severely impaired cognitive skills for daily decision-making. R79 displayed disorganized thinking that fluctuated. R79 displayed behaviors of hallucinations. R79 required supervision for activities of daily living (ADLs). R79 received antipsychotic medications on a routine basis. A GDR had not been attempted on R79's medications. R79's Quarterly MDS dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of three which indicated severely impaired cognition. R79 was dependent on staff for all functional abilities and care. R79 received antipsychotic medications on a routine basis. A GDR had not been attempted on R79's medications. (continued on next page)

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	175180	A. Building B. Wing	09/11/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R79's Psychotropic Drug Use Care Area Assessment (CAA) dated 12/28/23 documented he used psychotropic medications to manage psychiatric illnesses. A licensed nurse would monitor R79 for medication side effects each shift. A pharmacist consultant would review R79's medications monthly and the physician would review medications with each visit. R79's Care Plan last revised 02/27/24 directed staff to administer psychotropic medications as ordered. Staff was directed to document all behaviors and evaluate the side effects of the medications. R79's Order Summary Report from 12/15/23 to 09/11/24 documented an order dated 12/15/23 for Seroquel (an antipsychotic medication) 12.5 milligrams (mg) one time a day for hallucinations. R79's Order Summary Report from 12/15/23 to 09/11/24 documented an order dated 02/15/24 for Seroquel 12.5 mg one time a day for agitation and hallucinations. R79's Order Summary Report from 12/15/23 to 09/11/24 documented an order dated 03/22/24 for Seroquel 50 (mg) one time a day for agitation and hallucination. A review of R79's MRR from January 2024 to the present revealed the lack of a CP recommendation for a CMS-approved indication for use for Seroquel or a recommended GDR. R79's clinical records lacked a physician's documented clinical rationale for the continued use of Seroquel without a GDR or approved indication for use. The facility was unable to provide this information upon request. On 09/10/24 at 12:45 PM, R79 paced about the Serenity unit with a staff member. On 09/2/24 at 02:25 PM Administrative Nurse D stated the facility had been working with the physicians to attempt to decrease the use of the Seroquel unless contraindicated. Administrative Nurse D stated the facility had been working with the physician to ensure that an appropriate indication for use, and the risk versus benefit for the use of Seroquel was completed. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Tapering Medications and Gradual Drug Dose Reduction last revised in July 2022 documented that residents who used psychotropic medications should receive a gradual dose reduction, unless clinically contraindicated, to discontinue the use of such drugs. Pertinent behavioral interventions (refer to non-pharmacological attempts to influence an individual's behavior, including environmental alterations and staff approaches to care) would be attempted. Within the first year after a resident was admitted on a psychotropic medication or after the resident has been started on a psychotropic medication, the staff and practitioner shall attempt a GDR in two separate quarters (with at least one month between the attempts), unless clinically contraindicated. After the first year, the facility shall attempt a GDR at least annually, unless clinically contraindicated. For any individual who was receiving a psychotropic medication to treat behavioral symptoms related to dementia, the GDR may be considered clinically contraindicated if: the resident's target symptoms returned or worsened after the most recent attempt at a GDR within the facility; and the physician has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or increase distressed behavior. For any individual who was receiving a psychotropic medication to treat a psychiatric disorder other than behavioral symptoms related to dementia, the GDR may be considered contraindicated, if: the continued use was in accordance with relevant current standards of practice and the physician has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying psychiatric disorder, or the resident's target symptoms returned or worsened after the most recent attempt at a GDR within the facility and the physician has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder. The facility failed to ensure R79 had a CMS-approved indication or the required physician documentation, for use for antipsychotic medications without GDR attempts. This placed R79 at risk for unnecessary medication administration and possible adverse side effects.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 41713 The facility identified a census of 87 residents. The facility had one main kitchen and three dining areas. Based on observation, record review, and interview the facility failed to ensure the director of food and nutrition services had the required qualifications of a certified dietary manager (CDM). This placed residents at risk for unmet dietary and nutritional needs. Findings included: - On 09/10/24 at 11:29 AM Administrative Staff A stated that the facility was looking to employ a new CDM and more dietary staff. Administrative Staff A stated the Registered Dietician currently was at the facility at least twice a week but did there was not a CDM currently. The facility did not provide a policy regarding the CDM as requested. The facility failed to employ a full time director of food and nutrition services who had the required qualifications and/or a CDM. This placed residents at risk for unmet dietary and nutritional needs.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 41713 The facility identified a census of 87 residents. The facility had one main kitchen. Based on observation and interview, the facility failed to ensure staff stored food items in accordance with the professional standards for food service safety. The facility failed to ensure the high-temperature dishwasher was in proper working condition to wash and sanitize kitchenware and dishes. This placed residents at risk of foodborne illness and cross-contamination (the transfer of harmful substances to food). Findings included: - The initial tour of the kitchen on 09/09/24 at 07:06 AM revealed a dark kitchen with no staff present. Upon turning on the lights it was observed that an area approximately 15 feet by about four feet of the kitchen flooring was missing the ceramic tiles with the cement flooring exposed underneath (This area had empty food carts in the area with the missing tiles). Observance of the freezer temperature logs revealed no temperature reading since 09/07/24. The clean plates, stored in a plate service cart, did not have a cover over the plates. Upon entry to the walk-in refrigerator and freezer area, the following items were noted without a label or date: one clear sealed container of what looked like about 10 to 15 pre-cooked hot dogs had no label or use by date, one clear sealed container of pre-cooked sausage links without a label or use by date; a clear sealed container of cooked roast beef slices that lacked a label or use by date; two opened gallon jugs of milk that lacked an open date, one milk jug was covered with aluminum foil. On 09/10/24 at 11:00 AM a return visit to the kitchen. Consultant II reported that the main dishwashing machine was not reaching the optimal temperature of at least 180 degrees during the rinse cycle and had reported to maintenance to come look at it for repair. On 09/09/24 at 07:20 AM Dietary Consultant BB stated she had just gotten to work and had not had a chance to get the food items discarded. On 09/10/24 at 11:00 AM Consultant II stated staff should be labeling and dating all items that have been opened and should be dated with the use by date. Consultant II stated all food items should be stored in a sealed bag or container. Consultant II stated that the facility was in the process of some renovations and fixing the flooring in the kitchen was one of the items on the list. Consultant II stated she notified the maintenance director of the dishwasher not reaching the correct temperature to sanitize the dishware. On 09/10/24 at 12:45 PM Administrative Staff A stated he contracted a specialist to come look at the dishwasher and said it would be fixed by the end of the day. (continued on next page)

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	175180	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The updated Food Receiving and Storage policy documented that food shall be received and stored in a manner that complies with safe food handling practices. All food stored in the refrigerator or freezer will be covered, labeled, and dated (use by date). Label food prepped in-house that has been made with previously cooked and stored food with the discard date of the previously cooked item. Foods past their use by date must be discarded and cannot be used in food prep. Food that has been prepared can only be stored for four days from the cook date. Other opened containers must be dated and sealed or covered during storage. The facility failed to ensure dietary staff stored food items and washed dishes in accordance with the professional standards for food service safety. This placed residents at risk of foodborne illness and cross-contamination.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45668 The facility identified a census of 87 residents. The sample included 20 residents. Based on interviews and record reviews, the facility failed to conduct a thorough facility-wide assessment to determine the resources necessary to care for residents competently during both day-to-day operations and emergencies. This failure placed all 87 residents residing in the facility at risk for impaired care. Findings Included: - An inspection of the Facility assessment dated [DATE] provided by the facility revealed the following: The assessment did not identify the specific staffing levels needed for each unit and identify the number of Registered Nurses (RN), Licensed Nurses (LPN/LVN), Certified Medication Aides (CMA), and Certified Nurse Aides (CNA) needed for each unit, patient acuity, and census. The assessment lacked the staffing levels required for each shift. The assessment did not identify staffing-specific skill sets for each resident unit based on the resident population assessed of that unit. The assessment lacked an informed contingency plan for events that do not require activation of the facility's emergency plan but have the potential to impact resident care. The assessment lacked a plan to maximize recruitment and retention of direct care staff. The assessment did not identify the means of input gathered from the residents and their representatives when formulating the assessment data. On 09/11/24 at 02:45 PM Administrative Nurse D stated the facility was currently in the process of updating the facility assessment. The facility did not provide a policy related to its facility assessment as requested. The facility failed to conduct a thorough, updated facility-wide assessment to determine what resources were necessary to care for residents competently during both day-to-day operations and emergencies. This failure placed all 87 residents residing in the facility at risk for impaired care.

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	175180	A. Building B. Wing	09/11/2024

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634 The facility identified a census of 87 residents. The sample included 20 residents with one resident reviewed for hospice services. Based on observation, record review, and interviews, the facility failed to ensure a communication process was implemented, which included how the communication would be documented between the facility and the hospice provider, and a failed to provide a description of the services, medication, and equipment provided to Resident (R) 24 by hospice. This deficient practice created a risk of missed or delayed services and inadequate end-of-life care for R24. Findings included: - R24's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of fibromyalgia (condition of musculoskeletal pain, spasms, stiffness, fatigue, and severe sleep disturbance), pain, arthritis (inflammation of a joint characterized by pain, swelling, redness, and limitation of movement), brain damage, hypertension (HTN-elevated blood pressure), epilepsy (brain disorder characterized by repeated seizures), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), enteral nutrition (provision of nutrients through the gastrointestinal tract when the resident cannot ingest, chew, or swallow food), and dysphagia (swallowing difficulty). The Quarterly Minimum Data Set (MDS) dated [DATE] documented R24 had severely impaired cognition, and never or rarely made decisions. The MDS documented 24 had impairment on the upper and lower limbs of her body. The MDS documented R24 received hospice services during the observation period. R24's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 04/15/24 documented R24 had a cognition decline and was unable to comprehend. R24's Care Plan revised on 07/01/24 documented R24 was at the end of life with a diagnosis of terminal illness. R24 was to be admitted to hospice. R24's dignity and autonomy were to be maintained at the highest level. Nurses were to give medication as ordered. R24's Care Plan lacked documentation of communication with nursing staff to identify what the hospice provider was to provide. A review of the communication book provided by hospice revealed R24's signed terminal illness order and a plan of care provided by hospice. On 09/11/24 at 01:06 PM Certified Nursing Aide (CNA) M stated he thought the care plans for hospice were in the binders at the nurse's desk. On 09/11/24 at 01:19 PM Licensed Nurse (LN) E stated nurses do the initial care plan when a resident is admitted . LN E was unsure whose duty it was to ensure the facility care plans were updated with what the hospice provides. (continued on next page)

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	175180	A. Building B. Wing	09/11/2024

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/11/24 at 02:24 PM, Administrated Nurse D stated the facility collaborates with hospice through the plan of care. Administrative Nurse D stated the facility plan of care should include schedules for when hospice staff come to the facility, and what equipment and medication the hospice would provide. The facility did not provide a hospice policy. The facility failed to ensure collaboration between the facility and the hospice provider. This deficient practice placed R24 at risk of missed or delayed services and inadequate end-of-life care.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 49634 The facility identified a census of 87 residents. The facility identified eight residents on Enhanced Barrier Precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms that employ targeted gown and glove use during high contact care). Based on record reviews, observations, and interviews, the facility failed to implement signage or indicators within the physical environment to alert staff and visitors of the required EBP. The facility further failed to provide a Legionella (Legionella is a bacterium that can cause pneumonia in vulnerable populations) water management program to assess and mitigate the risk of Legionella and failed to maintain water temperatures to effectively clean and disinfect laundry. The facility further failed to ensure staff performed adequate hand hygiene, respiratory equipment was stored in a sanitary manner and failed to transport linens in a sanitary manner. These deficient practices placed the residents at risk for infectious diseases. Findings included: - An initial walkthrough of the facility was completed on 09/09/24 at 07:15 AM. An inspection of Resident (R)24's room revealed no protective equipment (PPE) readily available for EBP. R24 had no signage or indicators R24 was on EBP. R24 had a percutaneous endoscope gastrostomy tube (PEG-a tube inserted through the wall of the abdomen directly into the stomach). R24 had a suction cannula for suctioning the secretions in her throat. The cannula was in an undated, open bag that hung on her internal feeding pump. R24 had a nebulizer mask draped over her nebulizing machine. The mask was not in a sanitary container or clean barrier. An inspection of R57 's room revealed no readily available PPE for EBP. R57's room lacked signage or precaution indicators. R17 had a tracheostomy (opening through the neck into the trachea through which an indwelling tube may be inserted) and a PEG tube. R57's tracheal suction catheter was placed in an open bag which hung on R57's eternal feeding pole. R57's nebulizer sat on his bedside table, and the mask was without containment. An inspection of R58's room revealed no readily available PPE for EBP and lacked signage or precaution indicators. R58 had an intravenous (IV-administered directly into the bloodstream via a vein) catheter and a Foley catheter (a tube inserted into the bladder to drain urine into a collection bag). An inspection of R34's room revealed no readily available PPE for EBP and lacked signage or precaution indicators. R32 had a peripherally inserted central catheter (PICC-a thin, flexible tube that is inserted into a vein in the upper arm and threaded into a large vein above the heart). An inspection of R70's room revealed no readily available PPE for EBP and lacked signage or precaution indicators. R70 had a suprapubic catheter (urinary bladder catheter inserted through the abdomen into the bladder). An inspection of R69's room revealed readily available PPE for EBP and lacked signage or precaution indicators. R69 had a suprapubic catheter. (continued on next page)

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	175180	A. Building B. Wing	09/11/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An inspection of R37's room revealed readily available PPE for EBP and lacked signage or precaution indicators. R37 had a Foley catheter. An inspection of R60's room revealed readily available PPE for EBP and lacked signage or precaution indicators. R60 had a Foley catheter. On 09/09/24 at 08:12 AM R42's nasal cannula was wrapped around her oxygen canister, the cannula was uncontained in a sanitary manner. On 09/09/24 at 09:52 AM Certified Nursing Aide (CNA) PP carried unbagged wet sheets and clothing down the hall next to her clothing. On 09/10/24 at 07:01 AM on inspection of the laundry facilities, the washer temperature was reaching only 134 degrees Fahrenheit. Laundry Staff V stated the hot water, or boiler was not working properly. On 09/10/24 at 09:23 AM R39's CPAP mask laid directly on the CPAP machine unbagged. R39's oxygen tubing and nasal cannula were coiled and placed unbagged in the handle of the oxygen concentrator next to his bed. On 09/11/24 at 08:50 AM CNA PP and CNA QQ entered R14's room and donned gloves without performing hand hygiene first. CNA PP cleaned R14's front peri area and then rolled R14 to her side and cleaned her bottom wearing the same gloves. On 09/10/24 at 07:16 AM Maintenance Supervisor U stated the facility was in the process of getting a new boiler and there were issues with the hot water. Maintenance Supervisor U was unable to provide documentation that the water temperature was maintained at or above 165 degrees F. On 09/10/24 at 08:00 AM Administrative Staff A stated the facility was unable to provide a plan related to Legionella management and prevention. On 09/11/24 at 01:29 PM Administrative Nurse D stated hand hygiene should be performed when entering and leaving residents' rooms, and when going from clean to dirty. She stated soiled laundry should be bagged and never carried up the hall. Administrative Nurse D said she was not sure who should have EBP signage and PPE. On 09/11/24 at 02:29 PM Administrative Nurse D stated the EBP signage and PPE should be in every room for residents with EBP. She stated staff should never carry unbagged soiled laundry in the hall, and hand hygiene should be performed all the time, especially after patient care. The facility's Maintenance policy documented maintenance service shall be provided to all areas of the building, grounds, and equipment. The facility's Hand Hygiene policy documented This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. The facility's Legionella Water Management Policy documented the facility was committed to the prevention, detection, and control of water-borne contaminants, including Legionella. (continued on next page)

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	175180	A. Building B. Wing	09/11/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's Enhanced Barrier Precautions policy documented the facility will identify all residents needing to be placed on enhanced barrier precautions. The facility failed to implement signage or indicators within the physical environment to alert staff and visitors of the required EBP. The facility further failed to provide a Legionella water management program to assess and mitigate the risk of Legionella and failed to maintain water temperature to clean and disinfect laundry. The facility further failed to ensure staff performed adequate hand hygiene, respiratory equipment was stored in a sanitary manner and failed to transport linens in a sanitary manner. These deficient practices placed the residents at risk for infectious diseases.

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	175180	A. Building B. Wing	09/11/2024

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. 45668 The facility identified a census of 87 residents. Based on record review and interviews, the facility failed to ensure agency staff received the required communication training. This placed the residents at risk for impaired care and decreased quality of life. Findings included: - On 09/11/24 at 11:45 AM the facility was unable to provide proof of training records for agency staff. The staff reviewed were Certified Nurse's Aides (CNA) N, CNA O, and CNA P. On 09/11/24 at 02:40 PM Administrative Nurse D stated the facility did not keep records for the agency staff onsite. She stated the facility required the agency company to track their training and the facility did not verify or keep on record the agency staff's training or in-services. The facility was unable to provide the required training records as requested on 09/11/24. The facility's In-Service Training- All Staff policy (undated) indicated all staff were required to participate in regular in-service education. The policy noted agency or contractual staff were required to participate in orientation and annual in-service training. The facility failed to ensure the completion of the required communication training for staff who provided care in the facility. This placed the residents at risk for impaired care and decreased quality of life.

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F 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents. 45668 The facility identified a census of 87 residents. Based on record review and interviews, the facility failed to ensure agency staff received the required resident rights training. This placed the residents at risk for impaired care and decreased quality of life. Findings included: - On 09/11/24 at 11:45 AM the facility was unable to provide proof of training records for agency staff. The staff reviewed were Certified Nurse's Aides (CNA) N, CNA O, and CNA P. On 09/11/24 at 02:40 PM Administrative Nurse D stated the facility did not keep records for the agency staff onsite. She stated the facility required the agency company to track their training and the facility did not verify or keep on record the agency staff's training or in-services. The facility was unable to provide the required training records as requested on 09/11/24. The facility's In-Service Training- All Staff policy (undated) indicated all staff were required to participate in regular in-service education. The policy noted agency or contractual staff were required to participate in orientation and annual in-service training. The facility failed to ensure the completion of the required resident rights training for staff who provided care in the facility. This placed the residents at risk for impaired care and decreased quality of life.

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. 45668 The facility identified a census of 87 residents. Based on record review and interviews, the facility failed to ensure agency staff received the required infection control training. This placed the residents at risk for impaired care and decreased quality of life. Findings included: - On 09/11/24 at 11:45 AM the facility was unable to provide proof of training records for agency staff. The staff reviewed were Certified Nurse's Aides (CNA) N, CNA O, and CNA P. On 09/11/24 at 02:40 PM Administrative Nurse D stated the facility did not keep records for the agency staff onsite. She stated the facility required the agency company to track their training and the facility did not verify or keep on record the agency staff's training or in-services. The facility was unable to provide the required training records as requested on 09/11/24. The facility's In-Service Training- All Staff policy (undated) indicated all staff were required to participate in regular in-service education. The policy noted agency or contractual staff were required to participate in orientation and annual in-service training. The facility failed to ensure the completion of the required infection control training for staff who provided care in the facility. This placed the residents at risk for impaired care and decreased quality of life.