STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087245	A. BUILDING: _____ B. WING _____	02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE HOME PLUS LLC	6322 E PEACH TREE LANE WICHITA, KS 67218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of the licensure initial survey for the above named facility conducted on 01/27/21, 01/28/21, 02/01/21 and 02/02/21.	S 000		
S5105 SS=E	26-42-202 (a) Negotiated Service Agreement a) The administrator or operator of each home plus shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-42-202 (a)(1)(2) The facility reported a census of 8 residents. The sample included 3 residents. Based on interview and record review the operator failed to ensure the negotiated service agreement had an accurate description of services provided by an outside source and identification of the provider of each services for 2 of 3 sampled residents (#245 and #300).	S5105		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087245	A. BUILDING: _____ B. WING _____	02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE HOME PLUS LLC	6322 E PEACH TREE LANE WICHITA, KS 67218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5105	Continued From page 1 Findings included: - Review of the record for resident #300 revealed an admission date of 12/28/2020 with diagnosis of Parkinson's, essential tremor, diabetes mellitus type 2, restless leg syndrome, hypertension, depression and lumbar disc disease. The admission functional capacity screen dated 12/28/2020 identified the resident with impaired short-term memory and decision making. She needed physical assistance with bathing and supervision for dressing and transfers. She ambulated with a 3 wheeled walker and was identified as at risk for falls. The admission negotiated service agreement (NSA) dated 12/28/2020 lacked a description of services if any to be provided by an outside service provider. The NSA included "all services provided by a third-party provider will be billed by that agency to insurance and the resident for services rendered." A medical care provider's order signed 12/30/2020 ordered for physical therapy (PT)/occupational therapy (OT) to evaluate and treat the resident due to recent surgery and Parkinson's disease. Review of the nurse's notes revealed an entry dated 12/29/2020 at (unreadable time) which indicated an outside provider for PT/OT was contacted regarding the orders for PT/OT. Interview on 01/28/21 at 12:30 PM with licensed nurse/operator A confirmed the resident currently received PT/OT services from an outside provider and the NSA lacked this information.	S5105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087245	A. BUILDING: _____ B. WING _____	02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE HOME PLUS LLC	6322 E PEACH TREE LANE WICHITA, KS 67218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5105	Continued From page 2 The operator failed to ensure the negotiated service agreement had an accurate description of services provided by an outside source and identification of the provider of each services for this resident. - Record review for resident #245 revealed an admission date of 07/23/2020 with diagnoses of hypertension, falling, difficulty walking, muscle weakness, pain left knee, atherosclerotic heart disease (ASHD) and major depressive disorder. The admission functional capacity screen (FCS) dated 07/23/2020 identified the resident with cognitive deficit in all aspects, he needed physical assistance with bathing, dressing and supervision with walking/mobility. He had occasional bladder incontinence. The FCS indicated the resident used a brace, a walker, a wheelchair and was at risk for falls. The negotiated service agreement (NSA)/health service plan (HSP) dated 07/23/2020 and without any revisions included "I do have short term memory impairment according to my diagnosis that I have received from a physician." Falls management "I do have a history of falls according to my family and medical records". The NSA/HSP lacked any information about the resident receiving outside services for therapy and mental health counseling. Review of the nurse's notes between 07/16/2020 (no time) and 12/29/2020 (no time) revealed the resident admitted to the facility on 07/23/2020 at 11:45 AM. The note indicated the resident was alert, oriented, pleasant and cooperative. He used a left lower extremity brace, wore glasses and used a walker. A note dated 07/29/2020 at	S5105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087245	A. BUILDING: _____ B. WING _____	02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE HOME PLUS LLC	6322 E PEACH TREE LANE WICHITA, KS 67218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5105	Continued From page 3 10:00 AM included "therapy in to see patient" The NSA/HSP lacked information about the resident receiving an outside provider service for therapy. A note dated 12/07/2020 at 2:25 PM identified an appointment made for the resident to receive an outside provider in-house visit for counseling services on 12/08/2020. The NSA/HSP lacked information about the service being provided by an outside source. Interview on 01/28/21 at 12:30 PM with licensed nurse/operator A confirmed the resident received PT/OT services from an outside provider in the past and had in-house visits from a social worker for mental health. She confirmed the NSA lacked this information. The operator failed to ensure the negotiated service agreement had an accurate description of services provided by an outside source and identification of the provider of each services for this resident.	S5105		
S5155 SS=E	26-42-204 (a) Health Care Services (a) The administrator or operator in each home plus shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by:	S5155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087245	A. BUILDING: _____ B. WING _____	02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE HOME PLUS LLC	6322 E PEACH TREE LANE WICHITA, KS 67218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5155	Continued From page 4 KAR 26-42-204 (a) The facility reported a census of 8 residents. The sample included 3 resident. Based on observation, interview and record review licensed nurse/operator A failed to provide or coordinate the provision of necessary health care services to meet the needs for 3 of 3 sampled residents (#240, #245 and #300) in accordance with the functional capacity screening and the negotiated service agreement related to assistance with activities of daily living, cognition deficit, socially inappropriate behavior, wandering behavior, elopement risk, use of bed assistive devices and falls. Findings included: - Review of the record for resident #300 revealed an admission date of 12/28/2020 with diagnosis of Parkinson's, essential tremor, diabetes mellitus type 2, restless leg syndrome, hypertension, depression and lumbar disc disease. The admission functional capacity screen dated 12/28/2020 identified the resident with impaired short-term memory and decision making. She needed physical assistance with bathing and supervision for dressing and transfers. She could independently transfer, toilet and eat. She ambulated with a 3 wheeled walker and was identified as at risk for falls. The FCS lacked identification for the use of a bed assistive device. The admission negotiated service agreement (NSA)/health service plan (HSP) dated 12/28/2020 listed a service need with cognition-memory recall which included "I do have some memory impairment at times according to my family". The NSA/HSP lacked	S5155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087245	A. BUILDING: _____ B. WING _____	02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE HOME PLUS LLC	6322 E PEACH TREE LANE WICHITA, KS 67218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5155	Continued From page 5	S5155		

any directions or interventions to staff on how to manage the resident's cognitive deficit. The NSA/HSP included a service need of bathing which included "The community or hospice will provide assistance for bathing twice per week and as needed." The NSA/HSP lacked directions to staff on how much assistance to provide the resident with bathing. Licensed nurse/operator A reported the resident did not receive hospice services at all. The NSA/HSP included a service need for falls management which included "I do not have a history of falls according to my family". The FCS marked by licensed nurse/operator A indicated the resident was at risk for falls. The NSA/HSP lacked any directions to staff or interventions to reduce the resident's risk of falling. The NSA/HSP lacked information regarding the use of a bed assistive device.

Review of the nurse's notes revealed an entry dated 01/18/21 at 12:15 PM about the resident falling while attempting to sit in a chair in the dining room. The note indicated staff would encourage the resident to look and feel for the chair before sitting down. The NSA/HSP lacked information about the fall or this intervention.

Review of the facility's incident report dated 01/18/21 revealed no review of the incident for causal factors and no plan to reduce the risk for further falls.

Observation on 01/27/21 at 10:08 AM reveled an upside down U-shaped bed assistive device attached to the bed. The gap between the 2 upright bars measured approximately 18 inches.

Interview on 01/28/21 at 11:30 AM with licensed nurse/operator A confirmed the resident used the bed assist device. Licensed nurse/operator A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087245	A. BUILDING: _____ B. WING _____	02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE HOME PLUS LLC	6322 E PEACH TREE LANE WICHITA, KS 67218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5155	Continued From page 6	S5155		

reported she had not evaluated the bed assist device for safety and the NSA/HSP lacked information about the bed assist device. She confirmed the NSA/HSP lacked directions to staff of interventions to address the resident's cognition deficit, bathing abilities and fall risk.

The FDA (food and drug administration) Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment dated 3/10/06 listed 4 zones of greatest concern with specific measurements to reduce the risk of entrapment as follows:
Zone 1 within the rail should measure less than 4 and 3/4 inches
Zone 2 under the rail, between the rail supports or next to a single rail support should measure less than 4 and ¾ inches
Zone 3 between the rail and the mattress should measure less than 4 and 3/4 inches
Zone 4 under the rail at the ends of the rail should measure less than 2 and 3/8 inches.

Licensed nurse/operator A failed to provide or coordinate the provision of necessary health care services to meet the needs for resident #300 in accordance with the functional capacity screening and the negotiated service agreement related to assistance with activities of daily living, cognition deficit, assistive devices and falls.

- Record review revealed resident #240 admitted to the facility on 01/04/21 with diagnoses of anxiety, agitation dementia, depression, mood disorder and frequent urinary tract infection (UTI) (a fall risk factor).

The admission functional capacity screen (FCS) dated 01/04/21 indicated the resident had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087245	A. BUILDING: _____ B. WING _____	02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE HOME PLUS LLC	6322 E PEACH TREE LANE WICHITA, KS 67218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5155	Continued From page 7	S5155		

cognitive deficit in all aspects, needed physical assistance with bathing, dressing, toileting and supervision for transfers, walking and mobility. She had impaired decision making, wandering behavior, inappropriate behavior and fall risk.

The elopement risk assessment dated 01/04/21 included a score of 15 (7 or higher is high risk).

The negotiated service agreement (NSA)/health service plan (HSP) dated 01/04/21 included the following services meal preparation, laundry, housekeeping, environmental, shopping, financial management, transportation, telephone use, communication, vision, hearing, bathing, grooming, dressing, toileting, walking/mobility, falls management, eating, management of medications, cognition/memory recall and lifestyle. The NSA/HSP section for cognition/memory recall included "I do have memory impairment according to my family and diagnosis that I have received from a physician. Staff will remind me when it is mealtime and how to get around the house as needed". The NSA/HSP lacked directions to staff on how to address the resident's cognitive deficit or diagnosis of agitation dementia and anxiety. The NSA/HSP lacked information about the resident's socially inappropriate behavior, wandering behavior, risk for elopement and the use of a bed assistive devices. The NSA/HSP included for bathing "The community will provide assistance for bathing twice per week and as needed but lacked specific directions or interventions for the amount of assistance the resident needed for bathing. The section for toileting included "I am incontinent of the bladder at times and use briefs. Staff will assist me to change my brief and bed pads as needed". The NSA/HSP lacked directions/interventions of a schedule for assisting

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087245	A. BUILDING: _____ B. WING _____	02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE HOME PLUS LLC	6322 E PEACH TREE LANE WICHITA, KS 67218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5155	Continued From page 8	S5155		

the resident to the toilet to maintain as much bladder function as possible and for hygiene. The section for Falls Management "I do have a history of falls according to my family and medical records". The NSA/HSP lacked any information for cause of the resident's falls, directions or interventions to reduce the potential fall risk.

Review of the nurse's notes between 01/04/21 at 2:30 PM and 01/19/21 without a time (last entry) revealed no information regarding the resident's history of falls, socially inappropriate behavior, elopement risk, assistance needs with activities of daily living or use of a bed assist device.

Observation on 01/27/21 at 10:08 AM reveled an upside down U-shaped bed assistive device attached to the bed. The gap between the 2 upright bars measured approximately 18 inches. Observation on 01/27/21 at 11:26 AM revealed the resident had a large raised bruised area to the right forehead. Licensed nurse/operator A reported the resident had fallen that morning. Observation on 01/28/21 at 10:25 AM revealed the resident's face had dark blue/black bruising on the right forehead and eye area.

Interview on 01/28/21 at 11:30 AM with licensed nurse/operator A revealed no specifics about the resident's socially inappropriate behavior and she confirmed the NSA/HSP lacked identification and interventions to address this problem as indicated in the FCS. She confirmed the NSA/HSP lacked information related to the resident's wandering behavior and elopement risk. She confirmed the resident used the bed assist device. Licensed nurse/operator A reported she had not evaluated the bed assist device for safety and the NSA/HSP lacked information about the bed assist device. She confirmed the NSA/HSP lacked directions to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087245	A. BUILDING: _____ B. WING _____	02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE HOME PLUS LLC	6322 E PEACH TREE LANE WICHITA, KS 67218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5155	Continued From page 9	S5155		

staff of interventions to address the resident's cognition deficit, bathing abilities and fall risk.

The FDA (food and drug administration) Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment dated 3/10/06 listed 4 zones of greatest concern with specific measurements to reduce the risk of entrapment as follows:
Zone 1 within the rail should measure less than 4 and 3/4 inches
Zone 2 under the rail, between the rail supports or next to a single rail support should measure less than 4 and ¾ inches
Zone 3 between the rail and the mattress should measure less than 4 and 3/4 inches
Zone 4 under the rail at the ends of the rail should measure less than 2 and 3/8 inches.

Licensed nurse/operator A failed to provide or coordinate the provision of necessary health care services to meet the needs for resident #240 in accordance with the functional capacity screening and the negotiated service agreement related to assistance with activities of daily living, cognition deficit, socially inappropriate behavior, wandering behavior, elopement risk, use of bed assistive devices and falls.

- Record review for resident #245 revealed an admission date of 07/23/2020 with diagnoses of hypertension, falling, difficulty walking, muscle weakness, pain left knee, atherosclerotic heart disease (ASHD) and major depressive disorder.

The admission functional capacity screen (FCS) dated 07/23/2020 identified the resident with cognitive deficit in all aspects, he needed physical assistance with bathing, dressing and supervision

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087245	A. BUILDING: _____ B. WING _____	02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE HOME PLUS LLC	6322 E PEACH TREE LANE WICHITA, KS 67218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5155	Continued From page 10	S5155		

with walking/mobility. He had occasional bladder incontinence. The FCS indicated the resident used a brace, a walker, a wheelchair and was at risk for falls. A significant change FCS dated 09/08/2020 indicated the resident had improvement in short-term memory, needed physical assistance with bathing, dressing, toileting, transfers and supervision with waling/mobility. He had an increase in bladder incontinence to frequently and he remained at risk for falls. The significant change FCS dated 12/31/2020 indicated the resident had deficit in short-term memory and impaired decision making. He was now independent with activities of daily living other than supervision with bathing and had occasional bladder incontinence. Licensed nurse/operator A failed to mark the FCS with the resident's fall risk related to a fall he had in the past 180 days. The FCS dated 12/31/2020 indicated the resident had socially inappropriate behavior.

The negotiated service agreement (NSA)/health service plan (HSP) dated 07/23/2020 and without any revisions included no information related to socially inappropriate behaviors. The NSA/HSP included "I do have short term memory impairment according to my diagnosis that I have received from a physician." The NSA/HSP lacked any directions/interventions for staff to assist the resident with this problem. Falls management "I do have a history of falls according to my family and medical records". The NSA/HSP lacked information related to the resident's fall causal factors and directions/interventions to staff on reducing the risk for falls. The NSA/HSP for toileting included "I am incontinent of the bladder rarely and use briefs. Staff will assist me to change my brief and bed pads as needed". The NSA/HSP failed to match the incontinence level

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087245	A. BUILDING: _____ B. WING _____	02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE HOME PLUS LLC	6322 E PEACH TREE LANE WICHITA, KS 67218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5155	Continued From page 11 indicated in the FCS. Review of the nurse's notes between 07/16/2020 (no time) and 12/29/2020 (no time) revealed the resident admitted to the facility on 07/23/2020 at 11:45 AM. The note indicated the resident was alert, oriented, pleasant and cooperative. He used a left lower extremity brace, wore glasses and used a walker. On 07/24/2020 at 10:15 PM direct care staff B called licensed nurse/operator A to report the resident had fallen. The facility incident report dated 07/24/2020 indicated the resident was sitting on his walker and decided he wanted to sit on his bed, he stood up, his legs were getting tried and when he sat down, he was too close to the edge and lost his balance. Licensed nurse/operator A failed to update/revise the NSA/HSP to include this fall, causal factors and interventions to reduce the risk for further falls. A note dated 12/01/2020 at 7:00 PM revealed the resident became upset with staff, cursing and insulting the staff. Review of the activity of daily living notebook revealed a sheet titled Behavior Log. The log included an entry on 12/28/2020 of the resident being upset when staff reminded him of his fluid restriction. He started cursing, yelling and saying inappropriate things towards staff. On 01/04/21 resident very rude behavior today about everything said or done. On 01/18/21 6:15 AM he asked for a pain pill and when staff told him the medication was scheduled for 8:00 AM he began yelling and cursing. The NSA/HSP lacked directions to staff about the resident's behavior and how to manage the behavior. Interview on 01/28/21 at 11:30 AM with licensed nurse/operator A revealed no specifics about the resident's socially inappropriate behavior and she confirmed the NSA/HSP lacked identification and	S5155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087245	A. BUILDING: _____ B. WING _____	02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE HOME PLUS LLC	6322 E PEACH TREE LANE WICHITA, KS 67218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5155	Continued From page 12 interventions to address this problem as indicated in the FCS. She confirmed the NSA/HSP lacked directions to staff of interventions to address the resident's fall risk. Licensed nurse/operator A failed to provide or coordinate the provision of necessary health care services to meet the needs for resident #245 in accordance with the functional capacity screening and the negotiated service agreement related to socially inappropriate behavior and falls.	S5155		
S5192 SS=F	26-42-206 (e) Food Preparation (e) Food shall be prepared using safe methods that conserve the nutritive value, flavor, and appearance and shall be served at the proper temperature. (1) Food used by facility staff to serve to the residents, including donated food, shall meet all applicable federal, state, and local laws and regulations.(2) Food in cans that have significant defects, including swelling, leakage, punctures, holes, fractures, pitted rust, or denting severe enough to prevent normal stacking or opening with a manual, wheel-type can opener, shall not be used. (3) Food provided by a resident ' s family or friends for individual residents shall not be required to meet federal, state, and local laws and regulations. This REQUIREMENT is not met as evidenced by: KAR 26-42-206 (e)(1) The facility reported a census of 8 residents. Based on observation, interview and record	S5192		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087245	A. BUILDING: _____ B. WING _____	02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE HOME PLUS LLC	6322 E PEACH TREE LANE WICHITA, KS 67218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5192	Continued From page 13	S5192		

review the operator failed to ensure food used by facility staff to serve to residents met the state guidelines for food storage and served food at the proper temperature. This failure had the potential to affect all residents.

Findings included:

- During the entrance tour on 01/27/21 which began at 10:08 AM revealed the following food items in the refrigerator, freezer and cabinets without proper labeling, proper sealing and dates of when opened to ensure the items were used timely:
In the refrigerator
A plate full of shredded meat (unidentified), wrapped in plastic wrap without a date
A package of beef minute steaks without a thawed date (licensed nurse/operator A said she set it out to thaw 01/26/21
A plastic container identified as green salsa without a date
A small desert bowl with red jelled substance and fruit. The bowl had no date and liquid pooled in the bottom of the bowl.
A container of what appeared to be a rice dish without any identification or date
A plastic container with the corner of the lid raised up which held pasta and green beans with no identification or date
A bag of previously frozen blueberries now thawed with no date of when opened
An open bag of deli meat with no date of when opened
A bag of shredded cheese with no date of when opened
An open bag of bacon which had a date of when the meat packing company froze the meat and put into the meat locker but not a date of when taken from the freezer and opened. It was not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087245	A. BUILDING: _____ B. WING _____	02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE HOME PLUS LLC	6322 E PEACH TREE LANE WICHITA, KS 67218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5192	Continued From page 14 sealed, and the plastic was just folded over. The drawer in the bottom of the fridge had a red spills which resembled blood In the freezer open clear plastic bag of a bread product not identified and no date of opening An open plastic bag, not sealed and just folded over of toaster waffle An open partially used package of cream cheese without a date An open partial used container of a frozen desert with the lid partially lifted off and no date A plastic wrap bread type meat filled food without a date A zip-lock bag of a meat item (looks like chicken) stuck in the wire portion of the door, undeterminable identification of the food item or date. A gallon size plastic container of ice cream which was partially used and without a date. In the kitchen cabinets and counter On the counter a pan of cornbread covered in aluminum foil and no date An open unsealed bag of peanuts with no date An open, unsealed bag of bread with a best by date of 01/22/21 Two open, unsealed bags of potato chips A zip-lock bag of what appears to be cracker crumbs not identified and no date Two open unsealed bag of English muffins without a date of when opened several sleeves of opened, unsealed saltine crackers and no date of when opened Two boxes of opened vanilla wafers without a date An open partial bag of bagels with no date of when opened An open, unsealed bag of great northern beans and no date	S5192		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087245	A. BUILDING: _____ B. WING _____	02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE HOME PLUS LLC	6322 E PEACH TREE LANE WICHITA, KS 67218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5192	Continued From page 15 An open bag of rice without a date Interview on 01/27/21 at 10:30 AM with licensed nurse/operator A confirmed the above food items where not properly sealed, identified and dated as required. The Focus on Food Safety by Kansas Department of Agriculture dated 2014 directed food items must be date marked if it is prepared on-site or commercially processed, after the original container is opened and held under refrigeration. Potentially hazardous, ready-to-eat and held for more than 24 hours. The Focus on Food Safety directed to mark the date by which food is to be consumed or discarded. Food can be held for 7 days in adequate refrigeration. Day of preparation or day commercially processed food is opened counts as day one. Potentially hazardous or ready-to-eat food which is frozen should be marked to consume within 24 hours of removal from the freezer or when food is removed from the freezer mark with a consume by date that is 7 days minus the length of time the food was refrigerated before being frozen. The operator failed to ensure food used by facility staff to serve to residents met the state guidelines for food storage and served food at the proper temperature. This failure had the potential to affect all residents.	S5192		
S5210 SS=F	26-42-104 (b) Written Emergency Plan b) Each administrator or operator shall ensure the development of a detailed written emergency management plan to manage potential emergencies and disasters, including the following:	S5210		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087245	A. BUILDING: _____ B. WING _____	02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE HOME PLUS LLC	6322 E PEACH TREE LANE WICHITA, KS 67218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5210	Continued From page 16 (1) Fire; (2) flood; (3) severe weather; (4) tornado; (5) explosion; (6) natural gas leak; (7) lack of electrical or water service; (8) missing residents; and (9) any other potential emergency situations. This REQUIREMENT is not met as evidenced by: KAR 26-42-104 (b) The facility reported a census of 8 residents. Based on record review and interview the operator failed to develop a detailed written emergency management plan to manage potential emergencies and disasters as required for flooding, severe weather, tornado, explosion, lack of electrical or water service and missing resident with the potential to affect all residents. Findings included: - Review of the disaster plan notebook provided by licensed nurse/operator A on 01/28/21 revealed a 5 page document with the first page a list of emergency phone numbers. The next 4 pages were titled Emergency Handbook. The Handbook included fire emergencies, evacuation procedures, natural gas leak, building emergency/other pertinent information and accident reporting. The notebook lacked any directions to staff or residents on what to do in the event of flooding, severe weather, tornado, explosion, lack of electrical or water service or missing resident.	S5210		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087245	A. BUILDING: _____ B. WING _____	02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE HOME PLUS LLC	6322 E PEACH TREE LANE WICHITA, KS 67218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5210	Continued From page 17 Interview on 01/28/21 at 10:30 AM with licensed nurse/operator A confirmed the disaster/emergency plan notebook lacked detailed written procedures for the management of flooding, severe weather, tornado, explosion, lack of electrical or water service and missing resident. The operator failed to develop a detailed written emergency management plan to manage potential emergencies and disasters as required for flooding, severe weather, tornado, explosion, lack of electrical or water service and missing resident with the potential to affect all residents.	S5210		
S5215 SS=F	26-42-104 (d) Disaster and Emergency Preparedness Education (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the home ' s emergency management plan; (2) education of each resident upon admission to the home regarding emergency procedures; (3) quarterly review of the home ' s emergency management plan with employees and residents; and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-42-104 (d)(3)	S5215		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087245	A. BUILDING: _____ B. WING _____	02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE HOME PLUS LLC	6322 E PEACH TREE LANE WICHITA, KS 67218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5215	Continued From page 18 The facility reported a census of 8 residents. Based on interview and record review the operator failed to ensure residents and staff had disaster and emergency preparedness by a failure to conduct a quarterly review of the facility's emergency management plan with residents and staff. Findings included: - On 01/27/21 licensed nurse/operator A reported she admitted her first resident in July of 2020. 01/28/21 at 10:30 AM a request to review of the facility's disaster and emergency preparedness plan documentation for review with the residents and staff revealed licensed nurse/operator A lacked any documentation to prove she reviewed the emergency management plan with the residents and staff quarterly as required. The operator failed to ensure residents and staff had disaster and emergency preparedness by a failure to conduct a quarterly review of the facility's emergency management plan.	S5215		
S5230 SS=F	26-42-207 (b)(5)(6) (c) Infection Control Policies (b)(5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting;	S5230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087245	A. BUILDING: _____ B. WING _____	02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE HOME PLUS LLC	6322 E PEACH TREE LANE WICHITA, KS 67218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5230	Continued From page 19 (c) Each administrator or operator shall ensure the home ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. This REQUIREMENT is not met as evidenced by: KAR 26-42-207 (C) The facility reported a census of 8 residents. The sample included 3 residents. Based on record review and interview the operator failed to ensure the home's compliance with the State department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 regarding 3 of 3 residents sampled (#240, #245 and #300) and 4 of 5 newly hired employees licensed nurse/operator A and C, certified medication aide (CMA) E and certified nursing assistant (CNA) D. Findings included: - Record review for resident #240 revealed she admitted to the facility on 01/04/21. Licensed nurse/operator A planted the first step of the tuberculosis (TB) testing on 01/05/21 with no evidence of a second step planted within 3 weeks. Record review for resident #300 revealed she admitted to the facility on 12/28/2020. Licensed nurse/operator A planted the first step of the TB testing on 12/28/2020 with no evidence of a second step. Record review for resident #245 revealed he admitted to the facility on 07/23/2020. Licensed nurse/operator A planted the first step of the TB testing on 07/24/2020 with no evidence of a	S5230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087245	A. BUILDING: _____ B. WING _____	02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE HOME PLUS LLC	6322 E PEACH TREE LANE WICHITA, KS 67218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5230	Continued From page 20 second step. Interview on 01/28/21 at 10:30 AM with licensed nurse/operator A confirmed she did not perform the second step for TB testing on any of the residents. Review of the facility's undated Infection Control policy revealed each new resident and new employee shall receive a two-step TB test within 7 days of residency or employment. - Review of the personnel files for 4 newly hired employees revealed the following: Licensed nurse/operator A completed a first step only for TB on 05/08/2020 with no evidence of a second step. Licensed nurse B began employment on 01/20/21 with a first step administered on 01/23/21 and licensed nurse/operator A reported she had not been doing the second step of the TB test. Certified medication aide (CMA) E began employment on 05/14/2020 with her first step of TB test planted on 05/14/2020 and no evidence of a second test. Certified nursing assistant (CNA) C began employment on 05/14/2020 with the first step planted on 05/14/2020 and no evidence of a second step. Interview on 01/28/21 at 10:30 AM with licensed nurse/operator A confirmed she did not perform the second step for TB testing on any of the employees. Review of the facility's undated Infection Control policy revealed each new resident and new employee shall receive a two-step TB test within 7 days of residency or employment.	S5230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087245	A. BUILDING: _____ B. WING _____	02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE HOME PLUS LLC	6322 E PEACH TREE LANE WICHITA, KS 67218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5230	Continued From page 21 For all of the above findings, the operator failed to ensure the home's compliance with the State department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 regarding TB screening and testing for residents and newly hired employees.	S5230		
S5258 SS=F	26-42-102 (d) Staff Qualifications Employee Records (d) The employee records and agency staff records shall contain the following information: (1) Evidence of licensure, registration, certification, or a certificate of successful completion of a training course for each employee performing a function that requires specialized education or training; (2) supporting documentation for criminal background checks of facility staff and contract staff, excluding any staff licensed or registered by a state agency, pursuant to K.S.A. 39-970 and amendments thereto; (3) supporting documentation from the Kansas nurse aide registry that the individual does not have a finding of having abused, neglected, or exploited a resident in an adult carehome; and (4) supporting documentation that the individual does not have a finding of having abused, neglected, or exploited any resident in an adult care home, from the nurse aide registry in each state in which the individual has been known to work as a certified nurse aide. This REQUIREMENT is not met as evidenced by: KAR 26-42-102 (d)(3)	S5258		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087245	A. BUILDING: _____ B. WING _____	02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE HOME PLUS LLC	6322 E PEACH TREE LANE WICHITA, KS 67218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5258	Continued From page 22 The facility reported a census of 8 residents. Based on record review and interview the operator failed to have date stamped evidence of verification prior to providing care from the Kansas nurse aide registry for 3 of 3 newly hired direct care staff employees (certified medication aide {CMA} E and F; and certified nurse aide {CNA} D) with the potential to care for all residents. Findings included: - On 01/27/21 licensed nurse/operator A provided a list of employees hired since the facility opened 04/29/2020. Record review revealed 3 of 3 newly hired direct care staff (CMA E, F and CNA D) had a single page document to indicate the operator checked with the nurse aid registry. Neither CMA E, CMA F nor CNA D had a date on the page of when the verification occurred to ensure the verification was prior to providing care. Interview with licensed nurse/operator A confirmed the documents from the Kansas nurse aid registry lacked a date stamp of when the verification was made. The undated facility policy on Abuse, Neglect or Exploitation directed the home will not employ any individual who has been identified on a state nurse aide registry as having abused, neglected or exploited any resident in an adult care home. The operator failed to have date stamped evidence of verification prior to providing care from the Kansas nurse aide registry for 3 of 3 newly hired direct care staff employees (certified medication aide {CMA} E and F; and certified	S5258		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087245	A. BUILDING: _____ B. WING _____	02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE HOME PLUS LLC	6322 E PEACH TREE LANE WICHITA, KS 67218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5258	Continued From page 23 nurse aide {CNA} D) with the potential to care for all residents.	S5258		
S5286 SS=D	26-42-205 (b) Administration of Selected Medications (b) Administration of select medications. Any resident who self-administers medication may select some medications to be administered by a licensed nurse or medication aide. The negotiated service agreement shall reflect this service and identify who is responsible for the administration and management of selected medications. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (b) The facility reported a census of 8 residents. The sampled included 3 residents. Based on record review and interview licensed nurse/operator A failed to ensure the negotiated service agreement identified who was responsible for the administration and management of selected medications when the resident chooses to self-administer some of their medications and for the facility to manage selected medications for 1 of 3 sampled residents (#245). Findings included: - On 01/27/21 licensed nurse/operator A provided the completed resident roster which indicated the facility managed the medications and treatments for resident #245. She reported the resident had his medications administered by facility staff, but	S5286		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087245	A. BUILDING: _____ B. WING _____	02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE HOME PLUS LLC	6322 E PEACH TREE LANE WICHITA, KS 67218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5286	Continued From page 24	S5286		

he dialed the insulin pen and injected his insulin.

Resident #245 admitted to the facility on 07/23/2020 with diagnoses of hypertension, falling, difficulty walking, muscle weakness, pain left knee, atherosclerotic heart disease (ASHD) and major depressive disorder.

The significant change functional capacity screen (FCS) dated 12/31/2020 indicated the resident had deficit in short-term memory and impaired decision making. He lacked the ability to manage his own medications and needed physical assistance with treatments.

A self-administration of medication assessment dated 09/08/2020 indicated the resident was able to self-administer the insulin injections only by using an insulin pen. The previous assessment dated 07/23/2020 included "The resident is able to safely dial up insulin pens and self-inject subcutaneous with supervision by staff. Staff will keep all medications in the medication care or medication room and administer all by mouth medications as ordered.

The negotiated service agreement (NSA)/health service plan (HSP) dated 07/23/2020 and without any revisions included Management of Medications-"The facility will assist me with managing my medications per physician's orders. They will order, stock, administered, and record medication administration". The NSA/HSP lacked any information about insulin pens or the resident self-administering the insulin pen.

Interview on 01/28/21 with licensed nurse/operator A confirmed the resident self-managed his insulin pens and confirmed the NSA/HSP lacked this information.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087245	A. BUILDING: _____ B. WING _____	02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE HOME PLUS LLC	6322 E PEACH TREE LANE WICHITA, KS 67218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5286	Continued From page 25 Licensed nurse/operator A failed to ensure the negotiated service agreement identified who was responsible for the administration and management of selected medications when the resident chooses to self-administer some of their medications and for the facility to manage selected medications for this residents.	S5286		
S5300 SS=D	26-42-205 (d) (1-2) Facility Administration of Medications (d) Home administration of resident ' s medications. If a home is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the home has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-42-205 (d) The facility reported a census of 8 residents. The sample included 3 residents. Based on record review and interview the operator failed to ensure 1 of 3 sampled residents (#300) for whom the	S5300		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087245	A. BUILDING: _____ B. WING _____	02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE HOME PLUS LLC	6322 E PEACH TREE LANE WICHITA, KS 67218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5300	Continued From page 26 facility managed medications that all medications and biologicals were administered to the resident in accordance with a medical care provider's written order, professional standards of practice and manufacturer's recommendations. Findings included: - Review of the record for resident #300 revealed an admission date of 12/28/2020 with diagnosis of Parkinson's, essential tremor, diabetes mellitus type 2, restless leg syndrome, hypertension, depression and lumbar disc disease. The admission functional capacity screen dated 12/28/2020 identified the resident with impaired short-term memory and decision making. She lacked the ability to manage her own medications and treatments. The admission negotiated service agreement (NSA)/health service plan (HSP) dated 12/28/2020 listed a service need with cognition-memory recall which included "I do have some memory impairment at times according to my family". The NSA/HSP included "The facility will assist me with managing my medications per physician's orders. They will order, stock, administer, and record medication administration. Review of the admission orders and all orders obtained since then when compared to the January 2021 medication administration record (MAR) revealed an order for melatonin 5 milligrams (mg) 1 by mouth at bedtime for insomnia. The January 2021 MAR lacked this order. The December 2020 MAR lacked this order. The resident record lacked an order to discontinue the melatonin.	S5300		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087245	A. BUILDING: _____ B. WING _____	02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE HOME PLUS LLC	6322 E PEACH TREE LANE WICHITA, KS 67218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5300	Continued From page 27 Interview with licensed nurse/operator A on 01/28/21 at 11:00 AM confirmed she failed to transcribe the melatonin order to the December 2020 MAR and the January 2021 MAR. Review of the January 2021 MAR revealed the following PRN (as needed) medications administered by certified medication aides (CMAs) without evidence of consulting with a licensed nurse: Tylenol 650 mg by mouth every 6 hours PRN pain/fever initialed on the front of 10 administrations and on the back staff recorded 12 administrations without evidence of consulting with a licensed nurse for the complaint of neck pain and some had no reason listed. The January 2021 MAR included ibuprofen 400 mg by mouth every 6 hours PRN pain/fever. The front of the MAR had 32 doses initialed as administered with 23 of those were by CMAs. The back of the MAR included 33 entries with 24 of them by CMAs and none included evidence of consulting with the nurse. The reasons listed were for pain, ear pain, neck pain and oral pain. A request to review the medication management policy and procedures resulted in none provided. The operator failed to ensure this resident for whom the facility managed medications that all medications and biologicals were administered to the resident in accordance with a medical care provider's written order, professional standards of practice and manufacturer's recommendations.	S5300		
S5302 SS=D	26-42-205 (d) (4) Delegation of Medication Administration (4) Any licensed nurse may delegate nursing	S5302		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087245	A. BUILDING: _____ B. WING _____	02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE HOME PLUS LLC	6322 E PEACH TREE LANE WICHITA, KS 67218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5302	Continued From page 28 procedures not included in the medication aide curriculum to medication aides under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto. This REQUIREMENT is not met as evidenced by: KAR 26-42-205 (d) (4) The facility reported a census of 8 residents. The facility identified 1 resident #245 required blood glucose monitoring and the testing was complete by direct care staff (CMA-certified medication aide and CNA-certified nurse aide). Based on interview and record review the operator failed to ensure a licensed nurse oriented and instructed CMA E, CMA F and CNA D in the performance of blood sugar testing and further failed to document a demonstration of the staff's competency signed by the nurse and the CMA/CNA in each person's personnel record. Findings included: - On 01/27/21 licensed nurse/operator A provided the completed resident roster which indicated the facility managed the medications and treatments for resident #245. She reported the resident had his blood sugar tested by facility staff, but he dialed the insulin pen and injected his insulin. Resident #245 admitted to the facility on 07/23/2020 with diagnoses of hypertension, falling, difficulty walking, muscle weakness, pain left knee, atherosclerotic heart disease (ASHD) and major depressive disorder. The significant change functional capacity screen	S5302		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087245	A. BUILDING: _____ B. WING _____	02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE HOME PLUS LLC	6322 E PEACH TREE LANE WICHITA, KS 67218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5302	Continued From page 29	S5302		

(FCS) dated 12/31/2020 indicated the resident had deficit in short-term memory and impaired decision making. He lacked the ability to manage his own medications and needed physical assistance with treatments.

The negotiated service agreement (NSA)/health service plan (HSP) dated 07/23/2020 and without any revisions included Management of Medications-"The facility will assist me with managing my medications per physician's orders. They will order, stock, administered, and record medication administration". The NSA/HSP lacked any information about staff performing blood sugar testing.

The most recent medical care provider's orders included blood sugar testing fasting and 2 hours post prandial (after meal). The blood sugar testing log included initials of direct care staff who performed the blood sugar testing.

Observation on 01/27/21 at 11:16 AM CNA D prepared supplies and entered the resident's room to perform blood sugar testing. He explained to the resident what he planned to do, prepped the machine, cleaned the resident's thumb and used the lancet device to puncture the resident's skin for a drop of blood.

Interview on 01/27/21 at 1:15 PM with licensed nurse/operator A revealed she directed the CMAs and CNAs to perform the blood sugar testing on residents. She said she reviewed how to do the procedure with them but had no documentation of such or competency verification of their ability to accurately and safely perform the delegated task.

On 01/28/21 a request for the facility's policy on medication management and/or delegation of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087245	A. BUILDING: _____ B. WING _____	02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE HOME PLUS LLC	6322 E PEACH TREE LANE WICHITA, KS 67218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5302	Continued From page 30 nursing tasks resulted in none provided. The operator failed to ensure a licensed nurse oriented and instructed CMA E, CMA F and CNA D in the performance of blood sugar testing and further failed to document a demonstration of the staff's competency signed by the nurse and the CMA/CNA in each person's personnel record.	S5302		
S5313 SS=E	26-42-205 (g) (3) Over the counter medication (g) (3) A licensed nurse or medication aide may accept over-the-counter medication only in its original, unbroken manufacturer ' s package. A licensed pharmacist or licensed nurse shall place the full name of the resident on the package. If the original manufacturer ' s package of an over-the-counter medication contains a medication in a container, bottle, or tube that can be removed from the original package, the licensed pharmacist or a licensed nurse shall place the full name of the resident on both the original manufacturer ' s medication package and the medication container. This REQUIREMENT is not met as evidenced by: KAR 26-42-205 (g) (3) The facility reported a census of 8 residents. Based on observation, staff interview and record review the operator failed to ensure a licensed pharmacist or licensed nurse placed the full name of the residents on over the counter (OTC) medications for 6 of 8 sampled residents for whom the facility managed their medications (#240, #245, #300, #305, #308 and #311).	S5313		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087245	A. BUILDING: _____ B. WING _____	02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE HOME PLUS LLC	6322 E PEACH TREE LANE WICHITA, KS 67218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5313	Continued From page 31 Findings included: - On 01/27/21 licensed nurse/operator A provided a resident roster which identified the facility managed medications for all 8 residents. On 01/27/21 at 12:00 PM licensed nurse/operator A opened the only medication cart for inspection. Observation revealed the cart contained the following over the counter (OTC) medications which had no name, only a first name, only a last name or only initials: Resident #240 had (1) OTC medications without any identification and licensed nurse/operator A identified the bottle belonged to the resident. Resident #245 had (3) OTC containers which were labeled with his last name only Resident #300 had a zip-lock type plastic bag (8) OTC medications which had no name or only her last name. Resident #305 had (8) OTC medications with no name or the resident's last name only Resident #308 had (7) OTC medications 1 had only her first name and the others had only her last name Resident #311 had (4) OTC medications 2 were labeled with initials, 1 had no name and 1 had the first name only Interview 01/27/21 at 12:00 PM with licensed nurse/operator A confirmed the OTC medications lacked the required identification/labeling for the residents. The operator failed to ensure a licensed pharmacist or licensed nurse placed the full name of the resident on over the counter (OTC) medications for 6 of 8 residents.	S5313		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087245	A. BUILDING: _____ B. WING _____	02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE HOME PLUS LLC	6322 E PEACH TREE LANE WICHITA, KS 67218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5316	Continued From page 32	S5316		
S5316 SS=D	26-42-205 (i) Disposition of Medication (i) Accountability and disposition of medications. Licensed nurses and medication aides shall maintain records of the receipt and disposition of all medications managed by the home in sufficient detail for an accurate reconciliation. (1) Records shall be maintained documenting the destruction of any deteriorated, outdated, or discontinued controlled medications and biologicals according to acceptable standards of practice by one of the following combinations: (A) Two licensed nurses; or (B) a licensed nurse and a licensed pharmacist. (2) Records shall be maintained documenting the destruction of any deteriorated, outdated, or discontinued non-controlled medications and biologicals according to acceptable standards of practice by any of the following combinations: (A) Two licensed nurses; (B) a licensed nurse and a medication aide; (C) a licensed nurse and a licensed pharmacist; or (D) a medication aide and a licensed pharmacist. This REQUIREMENT is not met as evidenced by: KAR 26-42-205 (i) The facility reported a census of 8 residents and the facility managed the medications for all 8 residents. The sample included 3 residents. Based on observation, interview and record	S5316		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087245	A. BUILDING: _____ B. WING _____	02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE HOME PLUS LLC	6322 E PEACH TREE LANE WICHITA, KS 67218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5316	Continued From page 33	S5316		

review the operator failed to have an adequate system in place to ensure licensed nurses and certified medication aides maintained records in sufficient detail for an accurate reconciliation regarding controlled substances for resident #240.

Findings included:

- Record review revealed resident #240 admitted to the facility on 01/04/21 with diagnoses of anxiety, agitation dementia, depression, mood disorder and frequent urinary tract infection (UTI) (a fall risk factor).

The admission functional capacity screen (FCS) dated 01/04/21 indicated the resident had cognitive deficit in all aspects and lacked the ability to manage her own medications.

The negotiated service agreement (NSA)/health service plan (HSP) dated 01/04/21 included "The facility will assist me with managing my medications per physician's orders. They will order, stock, administer, and record medication administration."

On 01/27/21 at 12:00 PM licensed nurse/operator A opened the only medication cart for inspection. Review of the controlled substance medications compared to the reconciliation sheets revealed a discrepancies with the residents' Ativan (lorazepam) 0.5 milligrams (mg)/0.1 milliliters (ml) gel. The controlled substance box held 3 light sensitive bags with prefilled syringes of lorazepam. In the bag with a dispense date of 01/05/21 was 2 empty syringes and 1 syringe at 0.1 ml. The corresponding sheet looked like it said 0.0 ml. The bag with a dispense date of 01/20/21 indicated there should be 3 (1 ml)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087245	A. BUILDING: _____ B. WING _____	02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE HOME PLUS LLC	6322 E PEACH TREE LANE WICHITA, KS 67218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5316	Continued From page 34 prefilled syringes and the bag held 2 syringes each with 1.0 ml. The corresponding sheet read 2.6 ml with no evidence of correcting the dose. Licensed nurse/operator A explained the pharmacy had sent a syringe which was not completely filled. She provided an email communication with the pharmacy which included a picture showing this defective syringe which had about 0.36 ml. This syringe was not in the controlled substance box or accounted for. A 3rd bag had a full 1 ml syringe and no corresponding sheet. Licensed nurse/operator A reported that was the replacement syringe for the defective and she confirmed she failed to start a reconciliation sheet for that syringe. A request to review the facility's policy/procedure for controlled substance on 01/28/21 resulted in none provided. The operator failed to have an adequate system in place to ensure licensed nurses and certified medication aides maintained records in sufficient detail for an accurate reconciliation regarding controlled substances for this resident.	S5316		
S5335 SS=E	28-39-437 Construction (a) Each home-plus facility shall be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel, and the public. (b) All new construction, renovation, remodeling, and changes in building use in existing buildings shall comply with building and fire codes, ordinances, and regulations enforced by city, county, and state jurisdictions, including the state fire marshal.	S5335		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087245	A. BUILDING: _____ B. WING _____	02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE HOME PLUS LLC	6322 E PEACH TREE LANE WICHITA, KS 67218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5335	Continued From page 35 This REQUIREMENT is not met as evidenced by: KAR 28-39-437 (a) The facility reported a census of 8 resident. Licensed nurse/operator A identified all of the residents with cognitive impairment and independently mobile. Based on observation, interview and record review the operator failed to ensure the facility was equipped and maintained to protect the health and safety of residents, personnel and the public regarding unlocked chemicals and an unlocked exit door to the back yard which had an unlocked shed containing sharp tools, containers of gasoline and chair saw bar oil. Findings included: - On 01/27/21 during the initial tour of the facility at 10:08 AM revealed an unlocked exit door towards the back of the house which went into the back yard. The door freely opened with no alarm sounding. The fenced in back yard had a chicken coop with chickens and a heating lamp clearly visible, a pile of stones used in recent construction project, an unlocked shed which had various sharp gardening and house tools. The shed also had 2 containers of gasoline and a jug of chain saw bar oil. Outside by the shed was some more sharp yard tools. Licensed nurse/operator A reported the door had an alarm which they turned off during the day. She confirmed staff could be in a room helping another resident and not know a resident went out the door. Also, while on tour observation revealed the following unlocked and accessible chemical/products labeled keep out of reach of	S5335		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087245	A. BUILDING: _____ B. WING _____	02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE HOME PLUS LLC	6322 E PEACH TREE LANE WICHITA, KS 67218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5335	Continued From page 36 children or harmful if swallowed: In the common bathroom to the right of the front door under the sink in an unlocked cabinet was a spray bottle of Glitz no rinse sanitizer, and on the counter or in the drawers was a bottle of mouthwash, a bottle of anti-dandruff shampoo and a bottle of Oragel mouth rinse all of which said if swallowed get medical attention. In the bathroom off the kitchen area had a can of disinfectant spray on the back of the toilet, a bottle of mouthwash, a tube of Ultra strength analgesic cream, a bottle of hydrogen peroxide, a box of effervescent denture tablets and a bottle of Debrox ear was removal drops. In the kitchen unlocked cabinet under the sink was a spray bottle of cleaning vinegar with Oxi-clean labeled keep out of reach of children, a 75 fluid ounce bottle of ultra Dawn dishwashing liquid 3 times the concentration labeled keep out of reach of children and if swallowed give a glass of water and a 75 ounce jug of finish gel (for the dishwasher) labeled harmful if swallowed. Interview on 01/27/21 at 10:30 AM with licensed nurse/operator A confirmed the above items should be locked/secured to prevent the cognitively impaired and mobile residents from having access to them. The operator failed to ensure the facility was equipped and maintained to protect the health and safety of residents, personnel and the public regarding unlocked chemicals and an unlocked exit door to the back yard which had an unlocked shed containing sharp tools, containers of gasoline and chair saw bar oil.	S5335		
S9999	Final Observations	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087245	A. BUILDING: _____ B. WING _____	02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE HOME PLUS LLC	6322 E PEACH TREE LANE WICHITA, KS 67218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 37 K.S.A. 39-981 Adult care homes shall comply with all the lawfully established requirements and rules and regulations of the secretary of aging and the state fire marshal and any other agency of government so far as pertinent and applicable to adult care homes, their building, operators, staffs, facilities, maintenance, operation, conduct and the care and treatment of resident. This requirement is not met as evidenced by: Scope and Severity of an E The facility reported a census of 8 residents. The sample included 3 residents. Based on observation, interview and record review for residents #240 and #300 the operator failed to post a conspicuous notice at the entrance to the adult care home and each resident's room stating the rooms of some residents may be monitored electronically by or on behalf of the room's resident or residents. This deficient practice had the potential to affect all residents. Findings included: - During the entrance meeting on 01/27/21 with licensed nurse/operator A revealed one of the facility residents had a video and audio electronic monitoring system in their shared room. During the entrance tour on 01/27/21 which began at 10:08 AM observation revealed no signage on any of the resident's rooms or at the main entrance stating the rooms of some residents may be monitored electronically by or on behalf of the room's resident or residents.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087245	A. BUILDING: _____ B. WING _____	02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE HOME PLUS LLC	6322 E PEACH TREE LANE WICHITA, KS 67218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 38 Licensed nurse/operator A on 01/27/21 provided the required consent documents to use the electronic device for resident #240 and the roommate #300 and confirmed she failed to post any signs to reflect the use. The operator failed to post a conspicuous notice at the entrance to the adult care home and each resident's room stating the rooms of some residents may be monitored electronically by or on behalf of the room's resident or residents. This deficient practice had the potential to affect all residents.	S9999		