STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087239	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW LIFE HOME PLUS LLC	1214 N CHARLOTTE STREET WICHITA, KS 67208

(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 resurvey for the above named facility conducted on 08/30/22 - 08/31/22.	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) The facility reported a census of six residents with three included in the sample. Based on observation, interview, and record review the operator failed to ensure Resident (R) 830 and R831's, "Negotiated Service Agreements" (NSA) described the services each resident would receive based on their "Functional Capacity Screens" (FCS). Finding included:	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
	B087239	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW LIFE HOME PLUS LLC	1214 N CHARLOTTE STREET WICHITA, KS 67208

(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 - Record review for R830 revealed an admission date of 06/01/22 with diagnoses of dementia and diabetes. The 06/01/22 admission "Functional Capacity Screen" (FCS) identified R830 was sometimes understandable and usually understands others with communication; and was marked for falls and impaired hearing. The 06/01/22 Negotiated Service Agreement" (NSA) identified R830 had expressive aphasia (difficulty expressing speech) for communication, unsteadiness for falls, and was "very hard of hearing" for impaired hearing. R830's NSA lacked instructions for facility staff to prevent falls and to manage communication and hearing difficulties. The 07/05/22 "Observation Note by Administrative Nurse B documented R830 reported to staff he had fallen out of bed, got himself up, and went back to sleep during the night. He complained of pain in both knees which was worse in left knee. Observation on 08/31/22 at 02:19 PM revealed R830 slept in a recliner in his room. He wakened when staff and state surveyor entered his room. He smiled at state surveyor and shook his head and said no when staff asked him if he would talk with state surveyor. - Record review for 831 revealed an admission date of 05/30/22 with the following diagnoses: Alzheimer's disease, dementia, depression, anxiety, and weakness.	S5105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087239	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW LIFE HOME PLUS LLC	1214 N CHARLOTTE STREET WICHITA, KS 67208

(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 05/28/22 admission "FCS" identified R831 was usually understandable and sometimes understands other for communication, was marked for falls and inappropriate behavior. The 05/28/22 "NSA" identified R831 had expressive aphasia for communication. Falls and inappropriate behavior were not addressed. R831's record lacked instructions for facility staff to prevent falls and to manage communication and inappropriate behavior. The 06/04/22 "Observation Note" by Administrative Nurse B documented R831 "continued yelling out profanity and cursing." On 08/31/22 at approximately 02:25 PM Administrative Nurse B confirmed R830's NSA lacked instructions for staff to prevent falls and manage communication and impaired hearing and R831's NSA lacked instructions for staff to prevent falls and manage communication and inappropriate behavior. The operator failed to ensure R830 and R831's, "NSA's" described the services each resident would receive based on their "FCS'.	S5105		
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	S5230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087239	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW LIFE HOME PLUS LLC	1214 N CHARLOTTE STREET WICHITA, KS 67208

(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 3 annually on the control of infections in a health care setting; (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 26-207(c) The facility reported a census of six residents with three included in the sample. Based on interview and record review the operator failed to ensure the facility remained in compliance with Residents (R) 830 and 829 and three out of five staff sampled with the department's tuberculosis (TB) guidelines for adult care homes adopted by reference in KAR 26-39-105. Findings included: - Record review for R830 revealed an admission date of 06/01/22 with diagnoses of dementia and diabetes. The 06/01/22 admission "Functional Capacity Screen" (FCS) identified R830 required physical assistance for bathing, dressing, toileting, transfers, and walking/mobility; he was unable to perform management of medications and treatments; was occasionally incontinent of bladder; had short-term and long-term memory, memory/recall, and decision-making ability loss; was sometimes understandable and usually understands others with communication; and was marked for falls, impaired hearing, impaired decision making, and inappropriate behavior.	S5230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087239	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW LIFE HOME PLUS LLC	1214 N CHARLOTTE STREET WICHITA, KS 67208

(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 4 The 06/01/22 Negotiated Service Agreement" (NSA) identified facility staff would provide R830 physical assistance with one staff two to three times a week with bathing, physical assistance with one staff with dressing, toileting, transfers, bladder incontinence, would propel his wheelchair for walking/mobility, provide management of medications and treatments, cueing and reminders for cognition, assistance and reassurance for impaired decision making, and daily medication, supervision, and redirection when confused and anxious for inappropriate behavior. The 06/01/22 "Healthcare Service" (HCP) instructed facility staff to provide one-to-two-person total assist with bathing, physical assistance with one staff with dressing, one-to-two person assist with toileting and bladder incontinence, one person assist with transfers and wheelchair for walking/mobility, provide management of medications and treatments, and supervision or physical assistance for cognition. The 06/01/22 facility's "Tuberculosis Symptoms Review Questionnaire" documented R830 was administered the first step of a two-step TB skin test on 06/01/22. R830's record lacked documentation of the first-step TB skin test results and two-step TB skin test administration and results. On 08/31/22 at 11:13 AM Administrative Nurse B confirmed R830's TB skin test had not been completed. - Record review for R 829 revealed an admission	S5230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087239	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW LIFE HOME PLUS LLC	1214 N CHARLOTTE STREET WICHITA, KS 67208

(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 5 date of 01/04/21 with the following diagnoses: Parkinson's disease, dementia, and major depressive disorder. The 01/10/22 annual "FCS" identified R829 required physical assistance with bathing, supervision with dressing, toileting, and walking/mobility with a cane; he was unable to perform management of medications and treatments, was occasionally incontinent of bladder, had short-term memory, memory/recall, and decision-making loss; was marked for falls, impaired vision, impaired hearing and impaired decision-making. The 01/10/22 "NSA" identified facility staff would provide R829 physical assistance two to three times a week with bathing and bladder incontinence, supervision with dressing and walking/mobility with a cane; management of medications and treatments; cues, reminders, guidance and reassurance for cognition, he wore glasses for impaired vision, refused to wear hearing aids for impaired hearing and had a durable power of attorney (DPOA) for impaired decision making. The 01/10/22 "HCP" instructed facility staff to provide R829 one-person physical assist with bathing and dressing, cuing and reminders to change briefs for toileting and bladder incontinence, independent with a cane with walking/mobility, management of medications and treatments, and supervision or physical assistance and reassurance for cognition. The 01/04/21 "Tuberculosis Symptoms Review Questionnaire" documented R829 was administered the first step of a two-step TB skin test on 01/04/21 with negative results read on	S5230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087239	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW LIFE HOME PLUS LLC	1214 N CHARLOTTE STREET WICHITA, KS 67208

(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 6	S5230		

01/07/21. The second step was administered on 01/11/21 with negative results read on an unknown date.

R829's record lacked documentation an annual TB symptom screen review was completed one year from 01/04/21 (232 days later) and a date the second step TB test results were read.

On 08/31/22 at 02:02 PM Licensed Nurse (LN) C confirmed an annual symptom screen had not been completed for R829.

On 08/31/22 at approximately 02:35 PM Administrative Nurse B stated they completed yearly TB screenings on all the staff but did not do screenings on the residents.

- Review of Certified Medication Aid (CMA) D's employee record revealed a hire date of 02/01/21 and lacked evidence of TB testing.

Review of Licensed Nurse (LN) G's employee record revealed a hire date of 11/21/21. The first step of a two-step TB skin test was administered on 04/08/22 (139 days later).

Review of CMA E's employee record revealed a hire date of 02/01/21. The first step of a two-step TB skin test was administered on 03/16/21 (44 days later).

On 08/31/22 at 10:34 AM Administrative Staff A confirmed there was no documentation of TB testing for LN G upon hire.

The operator failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in KAR 26-39-105 regarding newly

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087239	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW LIFE HOME PLUS LLC	1214 N CHARLOTTE STREET WICHITA, KS 67208

(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 7 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: 26-42-102(d)(1)(2) The facility reported a census of six residents. Based on interview and record review the operator failed to ensure employee records contained evidence of licensure and certification for three of five sampled staff and supporting	S5258		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087239	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW LIFE HOME PLUS LLC	1214 N CHARLOTTE STREET WICHITA, KS 67208

(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 8	S5258		

documentation for criminal background checks for four out of five sampled staff upon hire.

Findings included:

- Review of Certified Medication Aid (CMA) D's employee record revealed a hire date of 02/01/21. The registry check date was 02/22/21 (10 days later) and the criminal background check date was 04/06/21 (65 days later).

Review of Certified Nurse Aid (CNA) H's employee record revealed a hire date of 02/28/22. The registry check date was 03/29/22 (30 days later) and the criminal background check date was 03/08/22 (nine days later).

Review of CMA E's employee record revealed a hire date of 02/01/21. The criminal background check date was 03/08/21 (36 days later).

Review of CNA F's employee record revealed a hire date of 07/02/22. The criminal background check date was 07/27/22 (26 days later).

Review of Licensed Nurse (LN) G's employee record revealed a hire date of 11/21/21. The registry check date was 11/28/21 (seven days later).

On 08/31/22 at 09:37 AM Administrative Staff A confirmed there were large gaps between hire dates and when registry checks and criminal background checks were completed for some staff.

The operator failed to ensure employee records contained evidence of licensure and certification for three of five sampled staff and supporting documentation for criminal background checks

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087239	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW LIFE HOME PLUS LLC	1214 N CHARLOTTE STREET WICHITA, KS 67208

(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 9 for four out of five sampled staff upon hire.	S5258		