STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087267	A. BUILDING: _____ B. WING _____	07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOIS HOUSE LLC	2758 N WELLESLEY AVE WICHITA, KS 67220

(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 represent the findings of a resurvey for the above named home plus facility conducted on 07/06/23 and 07/10/23.	S 000		
S5080 SS=E	26-42-201 (a) (b) Functional Capacity Screen on Admission (a) On or before each individual ' s admission to a home plus, a licensed nurse, a licensed social worker, or the administrator or operator shall conduct a screening to determine the individual ' s functional capacity and shall record all findings on a screening form specified by the department. The administrator or operator may integrate the department ' s screening form into a form developed by the home, which shall include each element and definition specified by the department. (b) A licensed nurse shall assess any resident whose functional capacity screening indicates the need for health care services. This REQUIREMENT is not met as evidenced by: KAR 26-42-201(a) The facility reported a census of five residents with all five included in the sample. Based on interview and record review the operator failed to ensure facility staff addressed cognition on the "Functional Capacity Screen" (FCS) for Resident (R) 1 and facility staff failed to comply within the	S5080		

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
	B087267	A. BUILDING: _____ B. WING _____	07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOIS HOUSE LLC	2758 N WELLESLEY AVE WICHITA, KS 67220

(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
S5080	Continued From page 1 definition specified by the department for cognition for R2 and R4. Findings included: - Record review for R1 revealed an admission date of 06/01/22 with a diagnosis of dementia. The 04/23/23 "FCS" failed to identify R1's capacity for cognition. The cognition section was left blank. -Record review for R2 revealed an admission date of 06/16/21 with the following diagnoses: post cerebrovascular accident with left-sided weakness and antisocial personality disorder. The 05/26/23 "FCS" identified R2 had a cognition score total of six which is not possible as the total score cannot exceed four if all four categories received the highest score of one. -Record review for R4 revealed an admission date of 01/19/22 with a diagnosis of Parkinson's disease. The 01/15/23 "FCS" identified R4 had a cognition score total of eight which is not possible as the total score cannot exceed four if all four categories received the highest score of one. On 07/11/23 at approximately 02:53 PM Administrative Staff A confirmed R1's cognition section on her "FCS" was blank and the cognition sections for R2 and R4 were scored incorrectly. The operator failed to ensure facility staff	S5080		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087267	A. BUILDING: _____ B. WING _____	07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOIS HOUSE LLC	2758 N WELLESLEY AVE WICHITA, KS 67220

(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
S5080	Continued From page 2 addressed cognition on the "FCS" for R1 and facility staff failed to comply within the definition specified by the department for cognition for R2 and R4.	S5080		
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 five residents with all five included in the sample. Based on interview and record review the operator failed to ensure the "Negotiated Service Agreement" (NSA) for Resident (R) 1 described the services provided and the provider of the services for treatments and communication and the "NSA" for R2 failed to describe the services and the	S5105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087267	A. BUILDING: _____ B. WING _____	07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOIS HOUSE LLC	2758 N WELLESLEY AVE WICHITA, KS 67220

(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 provider of the services for communication basedon their "Functional Capacity Screens" (FCS). Findings included: - Record review for R1 revealed an admission date of 06/01/22 with diagnoses of dementia and colostomy. The 04/23/23 "FCS" identified R1 was unable to perform management of treatments and was sometimes understandable and sometimes understood other during communication. The 04/07/23 "NSA" failed to describe the services provided R1 for management of treatments for colostomy care and communication to ensure her needs were known. The "NSA" also failed to identify the provider for colostomy care and communication. - Record review for R2 revealed an admission date of 06/16/21 with a diagnosis of post cerebrovascular accident with left-sided weakness. The 05/26/23 "FCS" identified R2 was sometimes understandable and sometimes understood other during communication. The 04/23/23 "NSA" failed to describe the services provider for communication to ensure his needs were known and also failed to identify the provider for communication. On 07/10/23 at approximately 02:53 PM	S5105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087267	A. BUILDING: _____ B. WING _____	07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOIS HOUSE LLC	2758 N WELLESLEY AVE WICHITA, KS 67220

(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 4 Administrative Staff A confirmed R1's "NSA" did not describe the services provided or the provider for management of treatments for her colostomy and for communication; and R2's "NSA" did not describe the services provided or the provider for communication. The operator failed to ensure the "NSA" for R1 described the services provided and the provider of the services for treatments and communication and the "NSA" for R2 failed to describe the services and the provider of the services for communication based on their "FCS."	S5105		
S5165 SS=D	26-42-204 (e) Delegation of Duties (e) A licensed nurse may delegate nursing procedures not included in the nurse aide or medication aide curriculums to nurse aides or medication aides, respectively, under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto. This REQUIREMENT is not met as evidenced by: KAR 26-42-204(e) The facility reported a census of five residents with all five included in the sample. Based on interview and record review the operator failed to ensure Certified Medication Aides (CMA) were trained and completed competencies for delegated nursing procedures to include changing an ostomy bag. Findings included:	S5165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087267	A. BUILDING: _____ B. WING _____	07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOIS HOUSE LLC	2758 N WELLESLEY AVE WICHITA, KS 67220

(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
S5165	Continued From page 5 - Review of R1's record revealed an admission date of 06/01/22 with the following diagnoses: dementia and colostomy. The 04/23/23 "Functional Capacity Screen" (FCS) identified R1 was unable to perform management of treatments. The 04/07/23 "Negotiated Service Agreement" (NSA) identified hospice would provide wound care treatments. The "NSA" did not address colostomy care. - Review of Certified Medication Aide (CMA) E's employee record revealed a hire date of 05/11/23. The employee record lacked evidence of documentation of skills competencies including changing an ostomy bag. On 07/10/22 at 11:39 AM CMA C stated R1 had a colostomy and the CMA's changed her bag twice a week. On 07/10/22 at 12:00 PM Administrative Staff A confirmed the CMA's changed R1's colostomy bag including cleaning her skin and applying new stoma paste. The department's 06/02/09 "Delegation of Nursing Tasks to Medication Aides and Nurse Aides Position Statement" documented the following: "(f) The designated nurse aide or medication aide to whom the nursing task is delegated shall be adequately identified by name, in writing, for each delegated task. (g) The licenses nurse shall orient and instruct the nurse aide or medication aide in the performance of the	S5165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087267	A. BUILDING: _____ B. WING _____	07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOIS HOUSE LLC	2758 N WELLESLEY AVE WICHITA, KS 67220

(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
S5165	Continued From page 6 nursing task. The nurse aide's or medication aide's demonstration of the competency necessary to perform the delegated task shall be documented in writing. The designated nurse aide or medication aide shall co-sign the documentation indicating the person's concurrence with this competency evaluation. (h) The licensed nurse will: (1) be accountable and responsible for the delegated nursing task; (2) participate in periodic and joint evaluations of the services rendered; (3) record and monitor recorded services: and (4) adequately supervise the performance of the delegated nursing task in accordance with the following conditions. . ." The operator failed to ensure Certified Medication Aides (CMA) were trained and completed competencies for delegated nursing procedures to include changing an ostomy bag.	S5165		
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	S5215		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087267	A. BUILDING: _____ B. WING _____	07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOIS HOUSE LLC	2758 N WELLESLEY AVE WICHITA, KS 67220

(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 7 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) The facility reported a census of five residents. Based on interview and record review the operator failed to provide quarterly reviews of the facility's emergency management plan with staff and residents and to conduct annual evacuation drills of the residents to a secure location. Findings included: - On 07/11/23 at approximately 10:42 AM the dates of the quarterly reviews of the facility's emergency management since the previous survey and the last two annual evacuation drills were requested which the facility failed to provide. On 03/28/23 at 11:52 AM Administrative Staff A confirmed there was no documentation of reviews of the emergency management plan with staff and residents and evacuation drills. The operator failed to provide quarterly reviews of the facility's emergency management plan with employees and residents and to conduct annual evacuation drills of the residents to a secure location.	S5215		
S5230 SS=F	26-42-207 (b)(5)(6) (c) Infection Control Policies	S5230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087267	A. BUILDING: _____ B. WING _____	07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOIS HOUSE LLC	2758 N WELLESLEY AVE WICHITA, KS 67220

(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 8 (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; (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 five residents with five residents included in the sample. Based on interview and record review the operator failed to ensure the facility remained in compliance with the department's tuberculosis (TB) guidelines for adult care homes adopted by reference in KAR 26-39-105 for Residents (R) 1, R2, R3, R3, and R5 and one staff employed by the facility. Findings included: - Record review for R1 revealed an admission date of 06/01/22 with the following diagnoses: dementia and type two diabetes mellitus. Her record lacked evidence of documentation of TB	S5230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087267	A. BUILDING: _____ B. WING _____	07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOIS HOUSE LLC	2758 N WELLESLEY AVE WICHITA, KS 67220

(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 9 testing and symptom screening completed upon admission and symptom screening completed annually. -Record review for R2 revealed an admission date of 06/16/21 with the following diagnoses: post cerebrovascular accident with left-sided weakness, and frequent falls. His record lacked evidence of documentation of TB testing and symptom screening completed upon admission and symptom screening completed annually. -Record review for R3 revealed an admission date of 07/20/21 with the following diagnoses: paranoid schizophrenia and epilepsy. His record lacked evidence of documentation of TB testing and symptom screening completed upon admission and symptom screening completed annually. -Record review for R4 revealed an admission date of 01/19/22 with the following diagnoses: Parkinson's disease, bilateral lower extremity weakness. His record lacked evidence of documentation of TB testing and symptom screening completed upon admission and symptom screening completed annually. -Record review for R5 revealed an admission date of 06/30/23 with the following diagnoses: quadriplegia and morbid obesity. His record lacked evidence of documentation of TB testing and symptom screening completed upon admission and symptom screening completed annually. - Record review Certified Nurse Aide (CNA) D revealed a hire date 05/11/23. Her record lacked	S5230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087267	A. BUILDING: _____ B. WING _____	07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOIS HOUSE LLC	2758 N WELLESLEY AVE WICHITA, KS 67220

(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 10 evidence of documentation of TB testing and symptom screening completed within seven days of hire. On 07/10/23 at 12:47 PM Administrative Staff A confirmed CNA D's record lacked evidence of documentation of TB testing and symptom screening completed within seven days of hire. On 07/10/23 at approximately 02:53 PM Administrative Staff A confirmed all five residents' records lacked documentation of TB testing and symptom screening completed upon admission and symptom screening completed annually. The department's June 2013 "Tuberculosis (TB) Guideline for Adult Care Homes" documented Each new resident and employee shall have an initial TB symptom screen that includes the components of the Tuberculosis Symptom Screen Questionnaire and shall receive a two-step TST or an IGRA within 7 days of residency or employment. Each resident and employee shall have an annual TB symptom screen that includes the components of the Tuberculosis Symptom Screen Questionnaire. 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.	S5230		
S5315 SS=F	26-42-205 (h) Medication Storage (h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s	S5315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087267	A. BUILDING: _____ B. WING _____	07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOIS HOUSE LLC	2758 N WELLESLEY AVE WICHITA, KS 67220

(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
S5315	Continued From page 11 recommendations or those of the pharmacy provider and with federal and state laws and regulations. (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the home in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the home in separately locked compartments within a locked medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals. (2) Each resident managing and self-administering medication shall store medications in a place that is accessible only to the resident, licensed nurses, and medication aides. (3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy provider may request that the medication be stored by the home. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(h)(1) The facility reported a census of five residents. Based on observation and interview the operator failed to ensure facility staff stored controlled	S5315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087267	A. BUILDING: _____ B. WING _____	07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOIS HOUSE LLC	2758 N WELLESLEY AVE WICHITA, KS 67220

(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
S5315	Continued From page 12 medications in separately locked compartments within a locked medication room, cabinet, or medication cart. Findings included: - Observation on 07/06/23 at 11:26 AM revealed a locked box in the main kitchen refrigerator. Certified Medication Aide (CMA) C unlocked the box to reveal two bottles of liquid lorazepam medication. On 07/06/23 at approximately 11:26 AM Administrative Staff A confirmed two bottles of liquid lorazepam were not in a separately locked compartment within a locked medication refrigerator. On 07/06/23 at 01:42 PM Administrative Nurse B confirmed two bottles of liquid lorazepam were not in a separately locked compartment within a locked medication refrigerator. On 07/10/23 at 11:27 AM a medications policy was requested which the facility failed to provide. The operator failed to ensure facility staff stored controlled medications in separately locked compartments within a locked medication room, cabinet, or medication cart.	S5315		
S5316 SS=E	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	S5316		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087267	A. BUILDING: _____ B. WING _____	07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOIS HOUSE LLC	2758 N WELLESLEY AVE WICHITA, KS 67220

(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 13 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 five residents. Based on interview and record review the operator failed to ensure a licensed nurse and medication aides maintained records of medications managed by the home for an accurate reconciliation when three controlled medications had less than the amount in their containers than was documented in the medication count book.	S5316		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087267	A. BUILDING: _____ B. WING _____	07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOIS HOUSE LLC	2758 N WELLESLEY AVE WICHITA, KS 67220

(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 14 Findings included: - Observations and record review of facility's controlled medications count reconciliation book on 07/06/23 at approximately 11: 30 AM revealed the following: 1) One bottle of liquid lorazepam 2 milligrams (mg)/1 milliliter (ml) in a locked box in the refrigerator contained 19.5 ml. The count reconciliation book documented 20.5 ml. 2) One bottle of liquid oxycodone 20 mg/ml in a separately locked compartment within the locked medication cart contained 8.0 ml. The count reconciliation book documented 9.25 ml. 3) A punch card of oxycodone/APAP 5/325 tablets in a separately locked compartment within the locked medication cart had five tablets left. The count reconciliation book documented 6 tablets. On 07/06/23 at approximately 11:38 AM Administrative Staff A and Certified Medication Aide (CMA) C confirmed three controlled medications contained less than what was documented in the reconciliation book. On 07/06/23 at 11:49 AM during a phone interview Administrative Nurse B stated facility staff had not reported the medication amounts and the count book were not reconciled. On 07/10/23 at 11:27 AM a medications policy was requested which the facility failed to provide.	S5316		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087267	A. BUILDING: _____ B. WING _____	07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOIS HOUSE LLC	2758 N WELLESLEY AVE WICHITA, KS 67220

(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 15 The operator failed to ensure a licensed nurse and medication aides maintained records of medications managed by the home for an accurate reconciliation when three controlled medications had less than the amount in their containers than was documented in the medication count book.	S5316		
S5335 SS=F	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. This REQUIREMENT is not met as evidenced by: KAR 28-39-437(a) The facility reported a census of five residents. Based on observation and interview the operator failed to ensure the building was maintained to protect the health and safety of the residents by ensuring all chemicals were stored within a locked area. Findings included: - Observation on 07/06/23 at 12:37 PM revealed the laundry room door was unlocked with the	S5335		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087267	A. BUILDING: _____ B. WING _____	07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOIS HOUSE LLC	2758 N WELLESLEY AVE WICHITA, KS 67220

(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 16 following chemicals on the floor with labels that read "Keep out of reach of children:" One 1.64-gallon bottle of Fabuloso Purple,lavender scent One 1-gallon bottle of Mr Clean multi-surface One 1.41 gallon-bottle of Clorox Cleaner +Bleach One 1.12 gallon-bottle of Pine Sol 6-8 more chemicals in spray cans and bottles in a box. On 07/06/23 at 12:41 PM Administrative Staff A confirmed chemicals were not in a locked area. The operator failed to ensure the building was maintained to protect the health and safety of the residents by ensuring all chemicals were stored within a locked area.	S5335		
S5380 SS=K	28-39-437 Plumbing and Piping Systems (i) Plumbing and piping systems. (1) Backflow prevention devices or vacuum breakers shall be installed on fixtures to which hoses or tubing can be attached. (2) Water distribution systems shall be arranged to provide hot water at hot water outlets at all times. The temperature of hot water shall range between 98° F and 120° F at showers, tubs, and lavatories accessible to residents. This REQUIREMENT is not met as evidenced by: KAR 28-39-437(i)(2) The facility reported a census of five residents.	S5380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087267	A. BUILDING: _____ B. WING _____	07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOIS HOUSE LLC	2758 N WELLESLEY AVE WICHITA, KS 67220

(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
S5380	Continued From page 17 There were two bathrooms which residents used for bathing and washing hands. Based on observation and interview the operator failed to ensure the temperature of hot water ranged between 98 degrees Fahrenheit (F) and 120 degrees F at faucets that were accessible to residents. This failure put four of the 5 residents at risk for severe burns which resulted in immediate jeopardy. Findings included: -Observations on 07/06/23 revealed the following: 12:46 PM - the water temperature in the unlocked back bathroom read 160.0 degrees F. Administrative Staff A checked it with her thermometer which read 158.8 degrees F. 12:48 PM - the water temperature in the unlocked front bathroom read 158.9 degrees F. Administrative Staff A checked it with her thermometer which read 157.1 degrees F. On 07/06/23 at 01:10 PM Certified Medication Aide (CMA) C stated facility staff adjusted the water heater settings last on 07/01/23. The water was too cold, so staff adjusted it to a hotter temperature setting. On 07/06/23 at approximately 01:10 PM review of the facility's water temperature log revealed it lacked the temperature range to keep residents safe from burns and instructions for staff when the temperature was out of range. On 07/06/23 at 01:12 PM Administrative Staff reported she had contacted the landlord to come	S5380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087267	A. BUILDING: _____ B. WING _____	07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOIS HOUSE LLC	2758 N WELLESLEY AVE WICHITA, KS 67220

(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
S5380	Continued From page 18 and fix the hot water heater. On 07/06/23 at 02:43 PM a water temperature policy was requested which the facility failed to provide. Immediate jeopardy was removed on 07/06/23 at 05:23 PM when the following actions were documented by the facility in the "Abatement Plan" and accepted by the department. 1) Check water temperature at all resident accessible faucets three times a day for 48 hours. 2) Check water temperature daily after it has stabilized. 3) Log water temperatures on a log to include date and time. 4) Train staff to check the water temperature when residents use the shower. 5) The plumber was called to check the hot water heater and stated it was fine on 07/06/23 at 04:23 PM. The operator failed to ensure the temperature of hot water ranged between 98 degrees F and 120 degrees F at faucets that were accessible to residents which put four residents at risk for severe burns.	S5380		
S9999	Final Observations KSA 39-928 Upon receipt of an application for license, the licensing agency with the approval of the state fire marshal shall issue a license if the applicant is fit and qualified and if the adult care home	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087267	A. BUILDING: _____ B. WING _____	07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOIS HOUSE LLC	2758 N WELLESLEY AVE WICHITA, KS 67220

(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 19	S9999		

facilities meet the requirements established under this law. The licensing agency, the state fire marshal, and the county, city-county or multicounty health departments or their designated representatives shall make such inspections and investigations as are necessary to determine the conditions existing in each case and a written report of such inspections and investigations and the recommendations of the state fire marshal and the county, city-county or multicounty health department or their authorized agents shall be filed with the licensing agency.

The licensing agency and the state fire marshal may designate and use county, city-county or multicounty health departments and local fire and safety authorities as their agents in making such inspections and investigations as are deemed necessary or advisable. Such local authorities are hereby authorized, empowered and directed to perform such duties as are designated. A copy of any inspection reports required by this section shall be furnished to the applicant.

A license, unless sooner suspended or revoked, shall remain in effect upon filing by the licensee, and approval by the licensing agency and the state fire marshal or their duly authorized agents, of an annual report upon such uniform dates and containing such information in such form as the licensing agency prescribes and payment of an annual fee.

Each license shall be issued only for the premises and persons named in the application and shall not be transferable or assignable. It shall be posted in a conspicuous place in the adult care home. If the annual report is not so

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087267	A. BUILDING: _____ B. WING _____	07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOIS HOUSE LLC	2758 N WELLESLEY AVE WICHITA, KS 67220

(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 20	S9999		

filed and annual fee is not paid, such license is automatically canceled. Any license granted under the provisions of this act shall state the type of facility for which license is granted, number of residents for which granted, the person or persons to whom granted, the date and such additional information and special limitations as are deemed advisable by the licensing agency.

This requirement is not met as evidenced by:

The facility reported a census of five residents. Based on observation, interview, and record review the operator failed to meet the requirements established by law to qualify for a license at a new location.

- Findings included:

Observation on 07/06/23 at 10:37 AM upon entrance to the current building revealed a license was not posted in a conspicuous location. There were three residents sitting in the common area and two residents were in their rooms.

Review of facility provided resident roster revealed five residents lived at the current location.

Review of a copy of the 30-day notice letters provided to residents and their families revealed a date of 04/13/23 which was 71 days before residents moved from the licensed location to the current building.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087267	A. BUILDING: _____ B. WING _____	07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOIS HOUSE LLC	2758 N WELLESLEY AVE WICHITA, KS 67220

(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 21 Review of the 06/01/23 "Pre-Eviction Notice of Termination of Rental Agreement for Nonpayment of Rent and Notice to Leave Property" revealed notice was provided to Administrative Staff A to vacate the licensed location 23 days before the residents moved to the current location. On 07/06/23 at 10:38 AM Administrative Staff A stated the residents moved from the licensed location to the current building on 06/23/23. She provided a copy of her license which lacked the address of the current location where the residents now resided. Scope and Severity of F. The operator failed to meet the requirements established by law to qualify for a license at a new location.	S9999		