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 _____	02/21/2024

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 a Re-Licensure survey for the above named Home Plus conducted on 02/20/24 and 02/21/24.	S 000		
S5028 SS=D	26-42-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the home as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation.	S5028		

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 _____	02/21/2024

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
S5028	Continued From page 1 This REQUIREMENT is not met as evidenced by: KAR 26-42-101(f)(3)(A) The facility reported a census of seven residents (R). The sample included three residents. Based on interview and record review for one (R4) of three sampled residents the operator failed to report and investigate R4's concerns that a man hit her. Findings included: - R4's medical record revealed she moved into the facility on 10/05/23 with diagnoses of schizophrenia. On 02/20/24 at 05:04 PM Operator/Licensed Nurse A reported the "Functional Capacity Screen", Negotiated Service Agreement", and the "Health Care Service Plan" (FCS/NSA/HCSP) are all one document. R4's FCS/NSA/HCSP revealed the resident needed staff to provide physical assistance with bathing, dressing , and toileting and had impaired cognition and impaired decision-making abilities. R4's nursing documentation revealed the following: 10/30/23 - Operator/Licensed nurse contacted R4's nurse case manager for a local health management company and left a voice mail that the resident kept saying, "he hit me, and it really hurt." Later that same day the nursing documentation revealed Certified Medication Aide B documented the resident said "He	S5028		

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 _____	02/21/2024

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
S5028	Continued From page 2 slapped me in the face" before leaving facility and stated it again when she returned to facility. The record included additional documentation from 11/03/23 to 02/13/24 comments the resident would say such as "he slapped me across the face and now I'm legally blind"; "(name) hurts me", "everything is going to be OK"; "You don't understand what I am going through"; "you can't use cocaine, it will kill you"; we don't do cocaine, we don't have that here"; (name) don't hit me, we are going to be OK (name)"; "(name) wouldn't hurt me"; "it's rough and I can't hardly handle it". On 02/21/24 at 04:49 PM Operator/Licensed Nurse A acknowledged she did not call the departments hot line. Operator/Licensed Nurse A stated she called R4's health management company and they said they would take care of it. The operator failed to report and investigate an allegation of physical abuse made by R4 to the department hot line within 24 hours.	S5028		
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:	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 _____	02/21/2024

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 (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 seven residents(R). The sample included three residents. Based on observation, interview, and record review for two (R3, and R4) of three sampled residents, the operator failed to ensure designated staff developed a "Negotiated Service Agreement" based on the resident's "Functional Capacity Screen" and the resident's service needs that included a description of the services the resident would receive. Findings included: - R3's medical record revealed she moved into the facility on 12/28/20 with diagnosis of diabetes mellitus type II and dementia. On 02/20/24 at 05:04 PM Operator/Licensed Nurse A reported the "Functional Capacity Screen", Negotiated Service Agreement", and the "Health Care Service Plan" (FCS/NSA/HCSP) are all one document. R3's FCS/NSA/HCSP dated 10/07/23 revealed the resident required physical assistance with all activities of daily living including mobility and for	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 _____	02/21/2024

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 4 staff to help the resident use her wheelchair for mobility. Observation on 02/20/24 at 03:23 PM Certified Medication Aide B pushed the resident back to her room to use the toilet and then pushed her to the living room when she was finished and transferred her into a recliner. On 02/21/24 at 10:43 AM Certified Medication Aide C reported R3 cannot propel herself in the wheelchair and she would need total assistance of staff to exit the house if there was an emergency. On 02/21/24 at 10:48 AM Operator/Licensed Nurse A acknowledged R3 was dependent on staff to get her out of the building in an emergency and that she did not address that service on the FCS/NSA/HCSP. The operator failed to ensure designated staff completed R3's "NSA" section of the document based upon her need for physical assistance to exit the facility in an emergency. - R4's medical record revealed she moved into the facility on 10/05/23 with diagnoses of schizophrenia. On 02/20/24 at 05:04 PM Operator/Licensed Nurse A reported the "Functional Capacity Screen", Negotiated Service Agreement", and the "Health Care Service Plan" (FCS/NSA/HCSP) are all one document. R4's FCS/NSA/HCSP revealed the resident had impaired cognition and wandering behavior.	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 _____	02/21/2024

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 5 During the two days of survey, 02/20/24 and 02/21/24, R4 walked throughout the facility following staff and others wherever they went. She followed surveyor and sad she was "going on a bus ride" which she takes to go to a local health management company. When surveyor asked R4 a question she would not always respond appropriately indicating she had some cognitive impairment. On 02/21/24 at 09:45 AM Certified Medication Aide D reported R4 walked by herself and would wander throughout the facility and staff had to redirect her if she went into another resident's room. On 02/21/24 at 04:56 PM Operator/Licensed Nurse A confirmed the resident had impaired cognition and wandered in the facility. She reviewed R4's FCS/NSA/HCSP and confirmed it did not include services related to her impaired cognition or her wandering. The operator failed to ensure designated staff completed R4's "NSA" section of the document based on R4's service needs as identified in the FCS.	S5105		
S5185 SS=E	26-42-206 (a) (b) (c) Dietary Services (a) The administrator or operator of each home plus shall ensure the provision or coordination of dietary services to residents as identified in each resident ' s negotiated service agreement. (b) The supervisory responsibility for dietetic services shall be assigned to one employee. (c) If a resident ' s negotiated service agreement	S5185		

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 _____	02/21/2024

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
S5185	Continued From page 6 includes the provision of a therapeutic diet, mechanically altered diet, or thickened consistency of liquids, a medical care provider ' s order shall be on file in the resident ' s clinical record, and the diet or liquids, or both, shall be prepared according to instructions from a medical care provider or licensed dietitian. This REQUIREMENT is not met as evidenced by: KAR 26-42-206 (c) The facility reported a census of seven residents(R). The sample included three residents, two of which received therapeutic diets. Based on observation, interview, and record review the operator failed to ensure two (R3 and R5) of three sampled residents record included approved instructions from a medical care provider or licensed dietitian on how to prepare R3's pureed diet and R5's ADA (diabetic) diet. Findings included: - Review of the resident roster provided by Operator/Licensed Nurse A on 02/20/24 revealed R3 and R5 received therapeutic diets. - R3's medical record revealed she moved into the facility on 12/28/20 with diagnosis of diabetes mellitus type II and dementia. On 02/20/24 at 05:04 PM Operator/Licensed Nurse A reported the "Functional Capacity	S5185		

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 _____	02/21/2024

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
S5185	Continued From page 7	S5185		

Screen", Negotiated Service Agreement", and the "Health Care Service Plan" (FCS/NSA/HCSP) are all one document.

R3's FCS/NSA/HCSP dated 10/7/23 revealed the resident required physical assistance with eating and staff were to encourage independence and assist as needed. It identified staff prepared her meals and she had a regular diet.

R3's record included a physician's order dated 12/1/23 to provide the resident a pureed diet and honey thickened liquids.

On 02/20/24 at 02:53 PM Certified Medication Aide (CMA) C reported R3 received a pureed diet and had her liquids thickened to honey consistency. CMA C was not sure if there were directions on how to prepare it. She stated they just put the food in the blender and blend it. If it was too dry, they would add a little water to it.

On 02/20/24 at 02:55 PM CMA C said she found the directions and put them in the back of the recipe book. The instructions titled "Blended Food Process" were not signed as being approved by a dietitian or a medical provider. The instructions included to "Pour in a liquid of your choice, such as water, juice, or milk to help with blending" for fruits and veggies. It did not direct staff on how to make meats thinner or what consistency the blended foods needed to be.

Observation on 02/21/24 at 09:01 AM CMA D sat beside R3 feeding her breakfast. She had been served chocolate chip pancakes, which she had already eaten, and staff was feeding her cottage

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 _____	02/21/2024

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
S5185	Continued From page 8	S5185		

cheese that had not been pureed.

Observation on 02/21/24 at 12:11 PM CMA C set two bowls of food in front of resident, mashed potatoes and pudding. CMA C stated since R3 cannot have chef salad gave her this. She stated she was going to fix some leftover pureed meatballs for protein.

Observation on 02/21/24 at 4:50 PM R3 sat at the table with a plate of regular consistency lasagna and peas. Staff stated the blender had broken. Operator/Licensed Nurse A told CMA C to get the blender from across the street and use it to puree her meal.

On 02/21/24 at 04:48 PM, Operator/Licensed Nurse A reported she did not realize the instructions for therapeutic diets needed to be approved by a medical provider or a dietitian.

The operator failed to ensure staff prepared and served R3 a pureed diet according to a medical provider or dietitian's approved instructions.

- R5's medical record revealed she moved into the facility on 01/22/23 with diagnoses of diabetes mellitus type II.

On 02/20/24 at 05:04 PM Operator/Licensed Nurse A reported the "Functional Capacity Screen", Negotiated Service Agreement", and the "Health Care Service Plan" (FCS/NSA/HCSP) are all one document.

R5's FCS/NSA/HCSP dated 03/24/23 identified she was independent with eating and facility staff would prepare and serve her an ADA (American

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 _____	02/21/2024

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
S5185	Continued From page 9 Diabetes Association) diet for three meals per day. On 02/21/24 at 08:56 AM resident sat at the breakfast table and ate 100% of her meal. Per CMA C she had chocolate chip pancakes and sausage. Observation on 02/21/24 at 12:09 PM resident was served chef salad and small bowl of pudding. On 02/21/24 at 1:30 PM Certified Medication Aide (CMA) C reported R5 usually ate the same foods as the other residents for meals unless her blood sugar is too high. CMA C said if R5's blood sugar is around 150 she will hold her desert or see what sugar free items they can give R5. Review of the recipe notebook included some diabetic recipes but did not include what foods she could or could not eat on an ADA diet. On 02/21/24 at 04:48 PM, Operator/Licensed Nurse A reported she did not realize the instructions for therapeutic diets needed to be approved by a medical provider or a dietitian. The operator failed to have instructions for preparing R5's ADA diet that were approved by her medical provider or by a licensed dietitian.	S5185		
S5251 SS=E	26-42-105 (f) (11) Resident Records Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including	S5251		

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 _____	02/21/2024

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
S5251	Continued From page 10 the date, time of occurrence, action taken, and results of the action. This REQUIREMENT is not met as evidenced by: KAR 26-42-105(f)(11) The facility reported a census of seven residents(R). The sample included three residents. Based on interview and record review the operator failed to ensure the medical record contained documentation of all incidents, symptoms, and other indications of illness or injury including the date and time, action taken, and results of the action for two (R3 and R4) of three sampled residents. Findings included: - R3's medical record revealed she moved into the facility on 12/28/20 with diagnoses of diabetes type II and dementia. On 02/20/24 at 05:04 PM Operator/Licensed Nurse A reported the "Functional Capacity Screen", Negotiated Service Agreement", and the "Health Care Service Plan" (FCS/NSA/HCSP) are all one document. R3's FCS/NSA/HCSP dated 10/07/23 revealed R3 required physical assistance with all activities of daily living and the facility staff would provide such assistance. It also identified she needed assistance of staff for management medications and medical treatments, and this would be provided by certified medication aides and	S5251		

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 _____	02/21/2024

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
S5251	Continued From page 11	S5251		

licensed nurses.

R3's physicians orders included an order dated 12/01/23 for pureed diet with honey consistency thickened liquids, no straws. The record lacked documentation as to symptoms the resident had that required the need to change her diet from regular to pureed and her liquids to thickened or if the change was effective.

R3's nursing progress notes included the following documentation:
From 05/06/23 to 12/13/23 the staff documented the resident had eight falls either out of bed or out of her recliner with no follow up to identify if the resident had latent injuries or if the interventions implemented to reduce risk or injury from falls worked.
10/24/23 received new order for honey thickened liquids. The record lacked documentation of problems prior to or effectiveness of changing R4's liquid consistency.
12/07/24 received new order for Lorazepam (antianxiety) daily in the evening. The record lacked documentation of symptoms prior to the initiation of the antianxiety medications and the effectiveness of the medication after it was initiated.

On 02/21/23 at 02:53 PM Certified Medication Aide C reported the resident received a pureed diet and had her drinks thickened to a honey consistency.

On 02/21/24 at 04:50 PM Operator/Licensed Nurse A stated they documented by exception and stated she did not see the need to follow up on the resident's status or effectiveness of the

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 _____	02/21/2024

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
S5251	Continued From page 12 medication or interventions as part of the exception. The operator failed to ensure the medical record contained documentation of all incidents, symptoms, and other indications of illness or injury including the date and time, action taken, and results of the action related to falls and symptoms which required medication or diet changes. - R4's medical record revealed she moved into the facility on 01/05/23 with a diagnosis of schizophrenia. On 02/20/24 at 05:04 PM Operator/Licensed Nurse A reported the "Functional Capacity Screen", Negotiated Service Agreement", and the "Health Care Service Plan" (FCS/NSA/HCSP) are all one document. R4's FCS/NSA/HCSP identified she needed physical assistance with bathing, dressing and toileting. She also had impaired cognition and needed a licensed nurse or certified medication aide to manage her medications. R4's record included the following nursing documentation: 10/16/23 - new order to increase 05:00 PM dosage of Seroquel (antipsychotic) to 100 milligrams (mg) and give it at 04:00 PM. The record lacked follow if the increase in dosage or change in time was effective in managing her behaviors. 02/01/24 - new order to increase bedtime Seroquel to 300 mg due to resident not sleeping. The record lacked documentation if the increase	S5251		

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 _____	02/21/2024

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
S5251	Continued From page 13 in Seroquel helped the resident to sleep or not. On 02/21/24 at 04:48 PM Operator/Licensed Nurse A reported the resident is sleeping now and staff should have documented on the effectiveness of the medication changes. The operator failed to ensure the medical record contained documentation of all incidents, symptoms, and other indications of illness or injury related to changes in antipsychotic medications.	S5251		
S5315 SS=D	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 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.	S5315		

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 _____	02/21/2024

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
S5315	Continued From page 14 (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)(4) The facility reported a census of seven residents. Based on observation and interview, the operator failed to ensure staff stored insulin pens according to manufacturer's recommendations to ensure medications were not administered beyond manufacturers recommended date of expiration. Findings included: - During initial tour on 02/20/24 at 02:29 PM Certified Medication Aide (CMA) B unlocked the medication cart for inspection. Observations included two insulin pens in the top drawer of the medication cart. The Tresiba flex pen, which had been used, did not include a date on it when staff initiated use of the pen. CMA B acknowledged insulin pens needed to have the date they were first used on them, but he did not know how long the pen had been in use. On 02/20/24 at 04:15 PM Operator/Licensed	S5315		

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 _____	02/21/2024

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
S5315	Continued From page 15 Nurse A confirmed that staff are supposed to put the date on insulin pens the first time they use it to know when it expires. Review of the Tresiba package instructions directed for the pen to be thrown away after 56 days in use, even if there is insulin left in it. The operator failed to ensure designated staff dated insulin Flexpen when staff initiated their use to ensure they were not administered beyond manufacturers recommended date of expiration.	S5315		