STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087237	A. BUILDING: _____ B. WING _____	04/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIFIED CARE HOME INC	5705 E ROCKHILL 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 a resurvey with a complaint #187451 at the above named Home Plus conducted on 04/25/24 and 04/29/24.	S 000		
S5085 SS=D	26-42-201 (c) Functional Capacity Screen Reassessment (c) Designated staff shall conduct a screening to determine each resident ' s functional capacity according to the following requirements: (1) At least once every 365 days; (2) following any significant change in condition as defined in K.A.R. 26-39-100; and (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant. This REQUIREMENT is not met as evidenced by: 5085 26-42-201(c)(1) The facility reported a census of six residents. The sample included three residents. Based on observation, interview, and record review the operator failed to ensure designated staff completed a "Functional Capacity Screen" (FCS) for resident (R)101 when he experienced a significant change in condition. Findings included: - R101's medical record revealed he moved into the facility on 08/01/23 with a diagnosis of	S5085		

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
	B087237	A. BUILDING: _____ B. WING _____	04/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIFIED CARE HOME INC	5705 E ROCKHILL 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
S5085	Continued From page 1	S5085		

dementia.

The most current FCS available in R101's medical records was dated 08/01/23 with no documentation to show a FCS was completed since this date.

On 04/25/24 at 03:45 PM two staff used a gait belt and walker to assist R101 to the restroom.

On 04/29/24 at 01:47 PM "Certified Medication Aide" (CMA) B stated R101 may require up to two staff for assist with transfers and mobilizing depending on if he was alert or not. If R101 was sleepy he required two staff to assist using a gait belt and was transferred to wheelchair or he used his walker with staff assistance. CMA B stated when R101 first arrived to the facility he was able to transfer and walk around independently and wandered around the home. CMA B stated R101 experienced a change in condition a few months back and was now on hospice and required the use of a walker/wheelchair and did not wander anymore.

On 04/29/24 at 02:20 PM "Licensed Nurse" (LN) C stated R101 initially was able to walk on his own and would walk around without the use of an assistive device. LN C stated R101 developed gait issues probably due to decline related to his dementia and now required up to two-person assist with transfers using a walker or wheelchair depending on his condition that day. LN C stated R101 was eventually placed on hospice. LN C stated she did not think a significant change FCS was completed for R101.

The operator failed to ensure designated staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087237	A. BUILDING: _____ B. WING _____	04/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIFIED CARE HOME INC	5705 E ROCKHILL 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
S5085	Continued From page 2 completed a FCS for R101 when he experienced a significant change in condition.	S5085		
S5095 SS=D	26-42-201 (d) Functional Capacity Screen Accurate (d) Designated staff shall ensure that each resident ' s functional capacity at the time of screening is accurately reflected on that resident ' s screening form. This REQUIREMENT is not met as evidenced by: 5095 KAR 26-42-201(d) 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 a resident's "Functional Capacity Screen" (FCS) accurately reflected the resident's status by the failure to complete the cognition portion of the FCS. Findings included: - Record review for resident (R)101 revealed an admission date of 08/01/23 with a diagnosis of dementia. R101's 08/01/23 Admission FCS did not have the cognition section completed. On 04/29/24 at 03:26 PM Administrative Nurse A	S5095		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087237	A. BUILDING: _____ B. WING _____	04/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIFIED CARE HOME INC	5705 E ROCKHILL 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
S5095	Continued From page 3 acknowledged the cognition section of the FCS was not completed. The operator failed to ensure R103's FCS accurately reflected his cognitive status by the failure to complete the cognition section of the FCS.	S5095		
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: 5105 26-42-202(a)(1) The facility reported a census of six residents with three residents included in the sample. Based on interview, and record review the operator failed to ensure the "Negotiated Service	S5105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087237	A. BUILDING: _____ B. WING _____	04/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIFIED CARE HOME INC	5705 E ROCKHILL 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 4	S5105		

Agreement" (NSA) was fully developed on what triggered in the "Functional Capacity Screen" (FCS) for resident (R)101, and R103.

Findings included:

- R101's medical record revealed he moved into the facility on 08/01/23 with a diagnosis of dementia.

The 08/01/23 FCS identified R101was sometime understandable and sometimes understands when communicating.

The 08/01/23 NSA did not address R101's did not address communication.

On 04/29/24 at 03:26 PM Administrative Nurse A acknowledged R101's NSA did not address communication.

The operator failed to ensure R101's NSA was fully developed to include all items that triggered in the FCS.

- R103's medical record revealed she moved into the facility on 04/01/22 with diagnoses of schizoaffective disorder, borderline personality disorder and severe depression.

The 04/01/24 FCS identified R103 exhibited socially inappropriate disruptive behaviors.

The 04/01/24 NSA did not address R103's socially inappropriate disruptive behaviors such as manipulation, lying, attention seeking, cutting or scratching herself and inappropriate use of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087237	A. BUILDING: _____ B. WING _____	04/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIFIED CARE HOME INC	5705 E ROCKHILL 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 5	S5105		

telephone.

On 04/29/24 at 01:59 PM "Certified Medication Aide" (CMA) B stated R103 required cues and reminders, and boundaries due to exhibiting behaviors. CMA B stated R103 manipulated staff to get around rules and had arm protectors because R103 cut or scratched herself.

On 04/29/24 at 03:41 PM CMA D stated R103 was selectively forgetful, manipulative, lied about staff and other residents. CMA D stated R103 called 911 numerous times to report she had suicidal thoughts without alerting facility staff. CMA D stated R103 self-seeking behaviors and tried to gain staff attention on a consistent basis even when staff were attending to the needs of other residents.

On 04/29/24 at 02:43 PM "Licensed Nurse" C stated R103 had many mental health issues to include self-seeking, and defiant behaviors. LN C stated staff had to put into place boundaries for R103 like to wait for staff while they attended to the needs of other residents and stated if there was something on R103's mind she expected staff to attend to this immediately. LN C stated R103 continuously used her phone and repeatedly called her, other professional providers and her guardian with non-emergent issues during the evening and weekdays.

On 04/29/24 at 03:26 PM Administrative Nurse A stated R103 had many mental health issues and acknowledged her NSA and care plan did not address her socially inappropriate disruptive behaviors.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087237	A. BUILDING: _____ B. WING _____	04/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIFIED CARE HOME INC	5705 E ROCKHILL 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 6 The operator failed to ensure R103's NSA was fully developed to include all items that triggered in the FCS.	S5105		
S5116 SS=D	26-42-202 (d) NSA revisions (d) Each administrator or operator shall ensure the review and, if necessary, revision of each negotiated service agreement according to the following requirements: (1) At least once every 365 days;(2) following any significant change in condition, as defined in K.A.R. 26-39-100; (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant; and (4) if requested by the resident or the resident ' s legal representative, staff, the case manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. This REQUIREMENT is not met as evidenced by: 5116 26-42-202(d)(2) The facility reported a census of six residents. The sample included three residents. Based on interview, and record review the operator failed to ensure the "Negotiated Service Agreement" (NSA) for resident (R)101 was reviewed and revised after he experienced a significant change in condition. Findings included:	S5116		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087237	A. BUILDING: _____ B. WING _____	04/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIFIED CARE HOME INC	5705 E ROCKHILL 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
S5116	Continued From page 7 - R101's medical record revealed he moved into the facility on 08/01/23 with a diagnosis of dementia. The most current NSA available in R101's medical records was dated 08/01/23 with no documentation to show a NSA was completed since this date. On 04/25/24 at 03:45 PM two staff used a gait belt and walker to assist R101 to the restroom. On 04/29/24 at 01:47 PM "Certified Medication Aide" (CMA) B stated R101 may require up to two staff for assist with transfers and mobilizing depending on if he was alert or not. If R101 was sleepy he required two staff to assist using a gait belt and was transferred to wheelchair or he used his walker with staff assistance. CMA B stated when R101 first arrived to the facility he was able to transfer and walk around independently and wandered around the home. CMA B stated R101 experienced a change in condition a few months back and was now on hospice and required the use of a walker/wheelchair and did not wander anymore. On 04/29/24 at 02:20 PM "Licensed Nurse" (LN) C stated R101 initially was able to walk on his own and would walk around without the use of an assistive device. LN C stated R101 developed gait issues probably due to decline related to his dementia and now required up to two-person assist with transfers using a walker or wheelchair depending on his condition that day. LN C stated R101 was eventually placed on hospice. LN C stated she did not think a significant change NSA	S5116		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087237	A. BUILDING: _____ B. WING _____	04/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIFIED CARE HOME INC	5705 E ROCKHILL 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
S5116	Continued From page 8 was completed for R101. The operator failed to ensure designated staff completed a NSA for R101 following a significant change in condition.	S5116		
S5126 SS=D	26-42-202 (h) NSA Signatures (h) Each individual involved in the development of the negotiated service agreement shall sign the agreement. The administrator or operator shall ensure that a copy of the initial agreement and any subsequent revisions are provided to the resident or the resident's legal representative. This REQUIREMENT is not met as evidenced by: 5126 26-42-202(h) The facility had a census of six residents. Three residents were included in the sample. The facility failed to ensure each individual involved in the development of the "Negotiated Service Agreement" (NSA) signed the agreement for one of three residents sampled. (Resident (R)103.) Findings included: - R103 admitted to the facility on 04/01/22 with a diagnosis of schizoaffective disorder, borderline personality disorder and severe depression. The 04/01/24 "Functional Capacity Screen" (FCS) revealed R103 had impaired	S5126		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087237	A. BUILDING: _____ B. WING _____	04/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIFIED CARE HOME INC	5705 E ROCKHILL 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
S5126	Continued From page 9 decision-making abilities. The 04/01/24 NSA did not include the signature of R103's court appointed legal guardian. On 04/30/24 at 12:50 PM Administrative Nurse A stated R103's guardian was involved in the development of the NSA. The operator failed to ensure the NSA was signed by the R103's legal representative.	S5126		
S5155 SS=D	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: 5155 KAR 26-42-204(a) The facility reported a census of six residents. The sample included three residents. Based on interview and record review the operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services to meet the needs for one of three sampled residents evidenced by the failure to address	S5155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087237	A. BUILDING: _____ B. WING _____	04/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIFIED CARE HOME INC	5705 E ROCKHILL 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
S5155	Continued From page 10	S5155		

resident (R)103's socially inappropriate disruptive behaviors and what interventions staff implemented to address these behaviors in the health care service plan.

Findings included:

- R103 admitted to the facility on 04/01/22 with a diagnosis of schizoaffective disorder, borderline personality disorder and severe depression.

The 04/01/24 "Functional Capacity Screen" (FCS) revealed R103 had impaired decision-making abilities and exhibited socially inappropriate disruptive behaviors.

The 04/01/24 "Negotiated Service Agreement" (NSA) documented staff redirected R103 as needed for inappropriate behaviors.

The 04/01/24 "Resident Service Plan" (RSP) documented phone calls to family and guardian would be limited to one to two times weekly. The RSP did not address specific behaviors such as manipulation, lying, attention seeking, or inappropriate use of the telephone and how staff addressed these behaviors. Furthermore, R103's court-appointed legal guardian did not sign the RSP as agreeing to limiting R103's ablility to make phone calls to the guardian and/or family to one to two times weekly.

The operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services to meet the needs for R103 when addressing her socially inappropriate, disruptive behaviors.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087237	A. BUILDING: _____ B. WING _____	04/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIFIED CARE HOME INC	5705 E ROCKHILL 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
S5315 SS=E	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. (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:	S5315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087237	A. BUILDING: _____ B. WING _____	04/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIFIED CARE HOME INC	5705 E ROCKHILL 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
S5315	Continued From page 12 5315 KAR 26-42-205(h) The facility reported a census of six residents. Based on observation and interview, the operator failed to ensure resident medications were securely and properly stored. Findings included: - An observation of the kitchen on 04/25/24 at 01:27 PM revealed the following prescription medications that were not labeled with a resident's name: One 100-gram tube of "Diclofenac Sodium Topical Gel." One 4-ounce tube of "Fast Freeze Pain Relieving Gel." The far-left drawer situated between the dishwasher a refrigerator contained a pill cup not labeled with a resident's name that contained two unidentified pills. On 04/25/24 at 02:30 PM "Certified Medication Aide" (CMA) B stated she had no idea who the pills belonged to or what the pills were. A policy for medication storage was requested on 04/29/24 but none was provided. The operator failed to ensure medications were securely and properly stored.	S5315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087237	A. BUILDING: _____ B. WING _____	04/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIFIED CARE HOME INC	5705 E ROCKHILL 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
S5335	Continued From page 13	S5335		
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: 5335 KAR 28-39- 437 (a) The facility reported a census of six residents. Based on observation, and interview the operator failed to ensure staff secured all chemicals to maintain the safety of all residents. Findings included: - Observations during initial tour on 04/25/24 revealed the following: At 01:17 PM observation of the east restroom revealed a 32-ounce (oz.) spray bottle of "LA's Totally Awesome Foaming Bathroom Cleaner" an aerosol spray can of Clorox Disinfectant Spray and a five-ounce spray can of "Homebright Disinfectant Spray" had a "Keep Out of Reach of Children" warning label. At 01:27 PM an observation of the unlocked kitchen cabinets revealed the following	S5335		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087237	A. BUILDING: _____ B. WING _____	04/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIFIED CARE HOME INC	5705 E ROCKHILL 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
S5335	Continued From page 14 chemicals: A 128 fluid ounce (fl. oz.) container of "Fabuloso Multi-Purpose Cleaner." A 10 oz. spray can of "The Home Stored Furniture Polish." A 23 fl. oz. spray bottle of "Windex." A 21 oz. container of "Ajax with bleach." A corner cabinet contained a 2.53-quart bottle of "Great Value Bleach." The cabinet underneath the kitchen sink contained a 3.78-quart container of "Tandil Concentrated Bleach" and a one-gallon container of "Great Value Lavender Scent Multi-Purpose Cleaner." A policy for chemical storage was requested on 04/29/24 but none was provided. The operator failed to ensure staff kept chemicals locked for resident safety.	S5335		
S5380 SS=F	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,	S5380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087237	A. BUILDING: _____ B. WING _____	04/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIFIED CARE HOME INC	5705 E ROCKHILL 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
S5380	Continued From page 15 tubs, and lavatories accessible to residents. This REQUIREMENT is not met as evidenced by: 5380 KAR 28-39-437(i)(2) The operator reported a census of six residents. The operator failed to ensure water temperatures in resident use areas did not exceed 120 degrees Fahrenheit (F). Findings included: - On 04/25/24 at 01:17 PM the east restroom had a hot water temperature of 133.5 F. On 04/25/24 at 01:27 PM the west restroom had a hot water temperature of 129.9 F. On 04/25/24 at 01:37 PM the kitchen sink had a hot water temperature of 137.1 F. Review of the "Water Temperature Log" revealed water temperatures were logged week with the last entry of 01/19/24. There were no water temperatures logged for the months of February, March or April. A policy concerning hot water temperatures was requested on 04/29/24 but none was provided. The operator failed to ensure water temperatures in resident use areas did not exceed 120 degrees Fahrenheit.	S5380		