STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087240	A. BUILDING: _____ B. WING _____	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE HOME PLUS LLC	400 N PETERSON AVE WICHITA, KS 67207

(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 Facility conducted on 05/23/24, 05/28/24 and 05/29/24.	S 000		
S 140 SS=E	26-39-103 (i) Resident Right Privacy and Confidentiality (i) Privacy and confidentiality. The administrator or operator shall ensure that each resident is afforded the right to personal privacy and confidentiality of personal and clinical records. (1) The administrator or operator shall ensure that each resident is provided privacy during medical and nursing treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups. (2) The administrator or operator shall ensure that the personal and clinical records of the resident are maintained in a confidential manner. (3) The administrator or operator shall ensure that a release signed by the resident or the resident's legal representative is obtained before records are released to anyone outside the adult care home, except in the case of transfer to another health care institution or as required by law. This STANDARD is not met as evidenced by: KAR 26-39-103(i)(1) The facility reported a census of six residents. Based on observations and interview, the operator failed to ensure staff provided two (R6 and R7) of six residents their right to personal privacy during toileting and incontinent care.	S 140		

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
	B087240	A. BUILDING: _____ B. WING _____	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE HOME PLUS LLC	400 N PETERSON AVE WICHITA, KS 67207

(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 140	Continued From page 1 Findings included: - Observations during the initial tour revealed the facility had two restrooms. One was a communal restroom for resident use and the other was kept locked for staff use only. Observation on 05/28/24 at 08:46 AM R3 walked past the "residents" restroom with R6 sitting on the toilet with her pants down and Certified Medication Aide (CMA) D assisting her. Continued observation revealed staff proceeded to assist R6 with toileting and helping to pull up her pants with the restroom door wide open. Observation at 08:52 AM Certified Nurse Aide (CNA) E took R7 into the same restroom and left the door wide open. CNA E proceeded to assist R7 to pull down her pants and sit on the toilet, removed her incontinent pullup, and put on a clean one. When the resident was finished R7 stood up allowing full view of resident as CNA E helped to pull up R7's pullup and pants. Interview on 05/28/24 at 08:58 AM CMA D reported sometimes the resident's wheelchair is in the way and cannot shut the door and sometimes we put the chair in the hallway. CMA D acknowledged the door should probably be shut to provide the resident privacy during toileting. Interview on 05/28/24 at 10:15 AM Operator/Licensed Nurse A confirmed staff should be shutting the restroom door providing privacy for the residents. The operator failed to ensure staff provided personal privacy while providing assistance with	S 140		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087240	A. BUILDING: _____ B. WING _____	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE HOME PLUS LLC	400 N PETERSON AVE WICHITA, KS 67207

(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 140	Continued From page 2 toileting, including incontinent care.	S 140		
S5026 SS=G	26-42-101 (f) (1) Staff Treatment of residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-42-101(f)(1)(B) The facility reported a census of six residents(R). The sample included three residents, with 3 residents sampled for neglect. Based on observations, interview, and record review the operator failed to ensure Resident (R) 5 was not subjected to neglect when the licensed nurse failed to identify service needs related to R5's high risk for pressure ulcers, failed to implement interventions and measures to reduce her risk for pressure ulcers, and failed to monitor R5's skin prior to the development of two stage II pressure ulcers (partial thickness ulcer involving the outer layer of skin and extending into the next layer of skin resulting in a shallow open wound or a blister containing clear fluid). One of R5's pressure ulcers deteriorated into a Stage III ulcer (ulcer effecting the full thickness of skin extending into the fatty tissue). The operator also failed to	S5026		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087240	A. BUILDING: _____ B. WING _____	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE HOME PLUS LLC	400 N PETERSON AVE WICHITA, KS 67207

(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
S5026	Continued From page 3	S5026		

ensure the licensed nurse implemented interventions to promote healing of R5's pressure ulcers after they developed.

Findings included:

- R5 moved into the facility on 12/18/23 with diagnosis of multiple sclerosis.

R5's current "Functional Capacity Screen" dated 12/18/23 identified the resident could not participate in all activities of daily living, including bathing, transfers, and mobility. R5 could not manage medical treatments, had urinary bladder incontinence, had impaired cognition, and impaired decision-making ability.

R5's current "Negotiated Service Agreement" (NSA) dated 12/18/23 revealed staff needed to provide physical assistance with mobility using a mechanical lift and wheelchair, provided physical assistance with toileting every two hours and she had a suprapubic catheter. It also identified she received physical assistance with bathing twice a week. The NSA identified licensed staff were to provide medical treatments, and hospice staff were to provide additional cares.

R5's NSA dated 12/18/23 lacked identification of services the facility would provide for the prevention of pressure ulcers due to being bedridden and having a history of sacral ulcers. The NSA did include a handwritten update dated 02/19/24 for wound care but lacked services to be provided and lacked evidence of R5's legal representative involvement.

R5's "Health Care Service Plan" (HCSP) dated 12/18/23 identified staff needed to feed the resident her meals. The HCSP failed to include

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087240	A. BUILDING: _____ B. WING _____	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE HOME PLUS LLC	400 N PETERSON AVE WICHITA, KS 67207

(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
S5026	Continued From page 4	S5026		

any health care services or staff instructions related to R5's risk for development of pressure ulcers. The HCSP did include a handwritten update on 02/19/24 that hospice provided wound care three times per week and noted R5's physician ordered daily dressing changes.

R5's "Skilled Nursing/Hospice" notes included the following:

On 01/10/24 the resident had a history of a pressure ulcer of the sacral region and is 100% dependent on caregivers for all activities of daily living. The resident is unable to purposefully move in bed to change positions and is high risk for developing skin breakdown. Education provided to the caregivers regarding skin care and prevention of skin breakdown.

On 02/09/24 no skin conditions were identified. The resident was identified as dependent on care givers for all activities of daily living, and she could not move in bed to change positions. R5 remained a high risk for development of pressure ulcers and continued to educate facility staff on skin care and prevention of skin breakdown.

On 02/12/24 the notes indicated the resident had no current skin conditions

On 02/16/24 staff identified a small discoloration on sacrum area, area as 1.0 centimeters (cm) length (l) ×1.5 cm width (w) deep red possibly developing into a pressure ulcer.

On 02/19/24 R5 developed two stage two pressure ulcers on her buttocks with one on the right inner leg ischial tuberosity (#1)and the other on the sacrum area (#2).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087240	A. BUILDING: _____ B. WING _____	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE HOME PLUS LLC	400 N PETERSON AVE WICHITA, KS 67207

(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
S5026	Continued From page 5 On 02/21/24 the note revealed the #1 stage II pressure ulcer measured 2.7 cm l x 2.1 cm w x 0.2 cm depth (d) and noted the wound had worsened. On wound #2 the documentation did not include measurements but noted the wound had worsened. On 02/26/24 pressure ulcer #1 worsened and was now identified as a stage III pressure ulcer that measured 2.5 cm l x 3.1 cm w x 1.2 cm d. The #2 pressure ulcer measured 2.1 cm l X 1.1 cm w x 0 d and noted it had improved. On 02/28/24 documentation on both wounds noted the pressure areas had increased in size and worsened in condition. On 03/08/24 the #1 stage III pressure ulcer measured 3.5 cm l x 2.3 cm w x 0.5cm d with 1.3 cm undermining (erosion under the wound edges, resulting in a large wound with a small opening) at 11 o'clock position and noted the wound had worsened. The #2 pressure ulcer measured 2.2 cm l x 1.0 cm w x 0.1 cm d and noted the wound had improved. On 03/20/24 The #1 stage III pressure ulcer worsened and now measured 3.5 cm l x 2.3 cm w x 1.2 cm d with 1.4 cm undermining at the 11 o'clock position. The #2 pressure ulcer measured 2.5 cm l x 1.0 cm w x 0.1 cm d and noted the wound had improved. Each of the "Skilled Nursing/Hospice" notes from 02/09/24 to 03/20/24 included documentation of education provided to staff and the resident on the importance of keeping her peri/rectal area clean and dry and for repositioning. Additional Skilled Nursing/Hospice notes starting	S5026		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087240	A. BUILDING: _____ B. WING _____	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE HOME PLUS LLC	400 N PETERSON AVE WICHITA, KS 67207

(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
S5026	Continued From page 6 03/22/24 included the pressure ulcers were treated aggressively, but due to the resident's unwillingness and inconsistency with repositioning the stage III pressure ulcer was getting worse. The writer talked to the nurse to assist the resident with turning and repositioning at least every two hours and also check on the resident to see if she had a bowel movement since the resident was unable to feel if she had. On 03/29/24 the #1 pressure ulcer measured 3.5 cm l x 2.6 cm w x 1.9 cm d with 2.0 cm undermining at the 11 o'clock position. The #2 pressure ulcer measured 2.2 cm l x 0.7 cm w x 0.1 cm in depth. On 04/10/24 the #1 pressure ulcer measured 3.5 cm l x 2.4 cm w x 1.3 cm d with undermining of 1.8 cm at the 11 o'clock position and 1.4 cm at the 1 o'clock position. The #2 pressure ulcer measured 1.5 cm l x .4 cm w x 0 cm d and had improved. The 04/10/24 note was the last documentation of pressure ulcer #2. On 05/22/24 the #1 pressure ulcer measured 3.8 cm lx 2.8 cm w x 1.4 cm d with 2.5 cm undermining at the 12 o'clock position and further noted no change in the wound. The wound showed little or no improvement from one visit to another, the area remained clean without any signs/symptoms of infection. The note documented that due to the resident's pain level she had a difficult time staying off her right side. Educated the RN to continue encouraging the resident to stay off her right side for at least for 30 minutes every two hours. The writer would continue to educate the facility staff regarding turning and repositioning for comfort and to prevention of further skin breakdown.	S5026		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087240	A. BUILDING: _____ B. WING _____	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE HOME PLUS LLC	400 N PETERSON AVE WICHITA, KS 67207

(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
S5026	Continued From page 7	S5026		

Review of "Physician Wound Orders" dated 03/13/24 included for R5 to be up in her Broda chair at least a couple of times a day.

Review of R5's FCS, NSA, HCSP, and nursing notes lacked any directions for staff to reposition the resident every two hours, to encourage the resident to be up and out of bed a couple hours per day, instructions for the use of a pressure relieving boots, or instructions should R5 choose not to get up or reposition in bed. The Nursing notes also failed to include documentation from the licensed nurse that she assessed the resident for skin condition issues and any description of R5's wounds, treatments, and results of the treatments. The record lacked documentation that facility staff educated the resident on the need to reposition every two hours, education to get up daily, and what could potentially happen should she choose to refuse services related to the prevention of pressure ulcers.

Observation on 05/23/24 at 01:05 PM revealed R5 positioned onto her right side.
Operator/Licensed Nurse A was in the room providing incontinent care. R5 had a foam dressing on her right gluteal fold that did not fully cover her wound, which resulted in part of the wound being exposed where the dressing did not cover it. Observation of R5 further revealed the resident had on bilateral heel boots.

During an observation on 05/23/24 at 01:12 PM Operator/Licensed Nurse A reported she was going to change R5's dressing since part of the pressure ulcer was not covered.
Operator/Licensed Nurse A prepared the overbed table with supplies for a dressing change. She positioned the resident onto her left side, removed the dressing and cleaned the area with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087240	A. BUILDING: _____ B. WING _____	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE HOME PLUS LLC	400 N PETERSON AVE WICHITA, KS 67207

(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
S5026	Continued From page 8	S5026		

wound cleanser. The resident had an open pressure ulcer with white coloration around the very edges of the opening., Operator/Licensed Nurse A wiped the area with betadine and revealed undermining around the edges of the wound from approximately the 11 o'clock position to the 1 o'clock position. Operator/Licensed Nurse A applied pixie dust in the wound bed, obtained the packing strips, packed the wound bed, and then placed calcium alginate pieces on top of the packing, and covered the wound with boarder gauze. Operator/Licensed Nurse A then positioned the resident with bolsters behind her back so she laid on her left side.

Observation on 05/28/24 at 02:18 PM Operator/Licensed Nurse A stated she had just turned R5 onto her right side. Observation at 3:12 PM, 04:00 PM, 04:48 PM, the resident remained on her right side. At 04:55 PM, two hours and 37 minutes after being on her right side, Operator/Licensed Nurse A reported she was going to reposition R5. Operator/Licensed Nurse A removed the pillows from under R5's right arm and behind her back and pulled the incontinent pad, so the resident scooted across the bed to the right side of the bed. She went to the other side of the bed and put a clean blue pad under the resident, rolling her side to side and then pulled her using the incontinent pad to the left side of the bed with the resident's bottom sliding across the bed. Operator/ Licensed Nurse A came back around to the right side of the bed and pulled her back to the right side of the bed again, potentially causing sheering to the wound area. Operator/Licensed Nurse A asked the resident to roll onto her left side, and R5 tried to move herself over while Operator/Licensed Nurse A put a bolster behind her back. Observation of R5's right hip where she had been laying had no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087240	A. BUILDING: _____ B. WING _____	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE HOME PLUS LLC	400 N PETERSON AVE WICHITA, KS 67207

(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
S5026	Continued From page 9	S5026		

redness.

Observation on 05/23/24 from 08:20 AM to 04:00 PM, on 05/28/24 from 02:10 PM to 05:50 PM, and on 05/29/24 from 07:14 AM to 11:52 AM revealed the resident R5 did not get out of bed as recommended by medical provider's order dated on 03/13/24.

Interview on 05/23/24 at 10:44 AM with Certified Nurse Aide (CNA) B reported she had worked in the facility since January of 2024 and R5 did not have pressure ulcers on her bottom when she first started working at the facility. CNA B confirmed R5 currently had pressure ulcers. CNA B reported R5 required two people to get her dressed and provide cares. CNA B reported they rotated R5 onto her side every two hours and further reported she would occasionally get out of the bed using a mechanical lift and two staff assistance.

Interview on 05/28/24 at 02:31 PM with CNA C reported R5 needed a lot of help with all her cares. R5 had a bath aide, and she had "sores" on her bottom, so staff tried to get R5 to move every two hours to prevent pressure on it. CNA C also reported the staff tried to get R5 out of bed twice a week.

Interview on 05/28/24 at 07:55 AM with CNA E reported R5 could help a little with repositioning and further reported they went in about every two hours to make sure R5 was on her side.

Interview on 05/28/24 at 07:56 AM with Certified Medication Aide D Reported staff got R5 up in the wheelchair on Mondays, Wednesdays, and Fridays.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087240	A. BUILDING: _____ B. WING _____	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE HOME PLUS LLC	400 N PETERSON AVE WICHITA, KS 67207

(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
S5026	Continued From page 10 On 05/29/24 at 10:08 AM Operator/Licensed Nurse A reported she identified a resident as at risk for pressure ulcers if they were unable to move themselves in the bed and then staff would have to reposition them. Operator/Licensed Nurse A acknowledged R5 was at risk for pressure ulcers when she moved into the facility. Operator/Licensed Nurse A reported that she and the hospice skilled nurse identified some redness on R5 but could not recall when it was initially identified. Operator Licensed Nurse A stated the wound progressed and the first week it looked like a red bruise starting to be a pressure ulcer and then it got worse. At that point, Operator/ Licensed Nurse A stated they tried to keep R5 repositioned to protect the area. Operator/Licensed Nurse A acknowledged she had had not identified R5's risk for ulcers on her admission FCS, NSA or HCSP, and further confirmed she did not include interventions to help reduce and prevent pressure ulcers outside of posting a turning schedule. Operator/ Licensed Nurse A also confirmed she did not revise the NSA or HCSP to include interventions once the resident developed Pressure ulcers. The operator failed to ensure R5 did not experience neglect when the licensed nurse failed to identify services, implement measures, and assess R5 related to her high risk for skin breakdown and the development of pressure ulcers.	S5026		
S5085 SS=E	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:	S5085		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087240	A. BUILDING: _____ B. WING _____	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE HOME PLUS LLC	400 N PETERSON AVE WICHITA, KS 67207

(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 11 (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: KAR 26-42-201 (c)(1) The facility reported a census of six residents. The sample included three residents. Based on observation, record review, and interview the administrator failed to ensure designated staff completed two (R3, R4, and R5) of three sampled resident's "Functional Capacity Screen" at least every 365 days or when the resident had a significant change in condition. Findings included: - R3 moved into the facility on 12/16/21 with diagnoses of diabetes mellitus type II, hemiparesis, and chronic obstructive pulmonary disease. R3's current "Functional Capacity Screen" dated 12/16/21 identified she needed physical assistance with all activities of daily living, unable to menage her medications or medical treatments, had impaired cognition, and at risk for falls. On the top right corner of the "Functional Capacity Screen" it had the following: "Review 12/16/22" with Operator/Licensed Nurse A's initials. "Review 12/16/23" with Operator/Licensed Nurse	S5085		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087240	A. BUILDING: _____ B. WING _____	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE HOME PLUS LLC	400 N PETERSON AVE WICHITA, KS 67207

(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 12	S5085		

A's initials.

- Review of R4's medical revealed she moved into the facility on 08/19/21 with diagnoses of obesity and restless leg syndrome.

R4's current "Functional Capacity Screen" (FCS) dated 08/18/21 revealed she was unable to participate in the tasks of bathing, dressing, toileting, mobility, and management of medications and medical treatments. She also had urinary incontinence and was at risk for falls. It did not include the use of a slide board for transfers.

On the top right corner of the FCS, it had the following:
"Review/update 08/19/22" with Operator/Licensed Nurse A's initials.
"Review 08/19/23" with Operator/Licensed Nurse A's initials.

On 05/29/24 at 09:28 AM Operator/Licensed Nurse A acknowledged she had not completed a new FCS for R3 and R4 every 365 days. Operator/Licensed Nurse A reported she thought she could just write the review dates up at the top of the previous FCS.

The operator failed to ensure a licensed nurse completed a FCS for R3 and R4 at least once every 365 days.

- R5's medical record revealed she moved into the facility on 12/18/23 with diagnoses of multiple sclerosis, and anxiety disorder.

R5's current "Functional Capacity Screen" (FCS) dated 12/18/23 revealed R5 was unable to participate in the task of bathing, dressing,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087240	A. BUILDING: _____ B. WING _____	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE HOME PLUS LLC	400 N PETERSON AVE WICHITA, KS 67207

(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 13 toileting, transfers, mobility, eating, and management of medications and medical treatments. She had urinary incontinence, impaired cognition and communication and impaired decision-making ability. On the top of R5's FCS included the following: "02/19/24 updated" with Operator/Licensed Nurse A's initials. R5's Hospice Skilled Nursing notes revealed R5 had changes to her skin starting on 02/14/24 which progressed into two stage II pressure ulcers with one worsening to a stage III. On 05/29/24 at 10:01 AM Operator/Licensed Nurse A reported she thought she was supposed to write the date at the top and any update on the FCS were appropriate. The operator/Licensed Nurse A failed to complete a FCS for R5 following a significant change in condition.	S5085		
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;	S5105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087240	A. BUILDING: _____ B. WING _____	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE HOME PLUS LLC	400 N PETERSON AVE WICHITA, KS 67207

(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 14 (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-42-202(a)(1) The facility reported a census of six residents(R). The sample included three residents. Based on observation, interview, and record review for two (R4 and R5) 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: - Review of R4's medical revealed she moved into the facility on 08/19/21 with diagnoses of obesity and restless leg syndrome. R4's current "Functional Capacity Screen" dated 08/18/21 revealed could not participate in the task of walking/mobility which identified she was totally dependent on staff to exit the facility in event of an emergency. R4's current "Negotiated Service Agreement" dated 08/19/21 failed to identify services on how she would exit the facility in the event of an emergency. Interview on 05/29/24 at 07:53 AM Certified Nurse Aide (CNA) E reported staff used the	S5105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087240	A. BUILDING: _____ B. WING _____	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE HOME PLUS LLC	400 N PETERSON AVE WICHITA, KS 67207

(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 15 mechanical lift to help R4 out of bed and into her wheelchair. CNA E stated once she is in the wheelchair someone had to push her to get from one place to another. On 05/29/24 at 10:58 AM Operator/Licensed Nurse A reported she did not know the NSA needed to identify how staff would evacuate R5 in the event of an emergency. The operator failed to identify how R4 would exit the facility in the event of an emergency. - R5's medical record revealed she moved into the facility on 12/18/23 with diagnoses of multiple sclerosis, and anxiety disorder. R5's current "Functional Capacity Screen" dated 12/18/23 revealed she could not participate in the task of walking/mobility, indicating she was totally dependent on staff to exit the facility in case of an emergency. R5's current "Negotiated Service Agreement" dated 12/18/23 failed to include services on how she would exit the facility in the event of an emergency. On 05/29/24 at 10:58 AM Operator/Licensed Nurse A reported she did not know the NSA needed to identify how staff would evacuate R5 in the event of an emergency. The operator failed to identify how R5 would exit the facility in the event of an emergency.	S5105		
S5116 SS=D	26-42-202 (d) NSA revisions (d) Each administrator or operator shall ensure	S5116		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087240	A. BUILDING: _____ B. WING _____	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE HOME PLUS LLC	400 N PETERSON AVE WICHITA, KS 67207

(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 16 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: KAR 26-42-202(d)(1) The facility reported a census of six residents (R). The sample included three residents. Based on observation, record review, and interview the administrator failed to ensure designated staff reviewed and revise one (R3) of three sampled resident's "Negotiated Service Agreement" at least every 365 days. Findings included: - R3 moved into the facility on 12/16/21 with diagnoses of diabetes mellitus type II, hemiparesis, and chronic obstructive pulmonary disease. R3's current "Functional Capacity Screen" dated 12/16/21 identified she needed physical assistance with all activities of daily living, could not manage her medications or medical treatments, had impaired cognition, and was at	S5116		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087240	A. BUILDING: _____ B. WING _____	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE HOME PLUS LLC	400 N PETERSON AVE WICHITA, KS 67207

(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 17 risk for falls. R3's current "Negotiated Service Agreement" (NSA) was last reviewed on 02/13/23 indicating it had not been reviewed at least once every 365 days. On 05/29/24 at 09:34 AM Operator/Licensed Nurse A reviewed R3's NSA and acknowledged it had not been reviewed and reviewed at least every 365 days. The operator failed to ensure designated staff completed R3's NSA at least once every 365 days.	S5116		
S5126 SS=E	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: KAR 26-42-202 (h) The facility reported a census of six residents (R) and the sample included three residents. Based on interview and record review for two (R4 and R5) of three sampled residents, the operator failed to ensure that everyone involved in the development of the "Negotiated Service Agreement" signed the agreement. Findings included:	S5126		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087240	A. BUILDING: _____ B. WING _____	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE HOME PLUS LLC	400 N PETERSON AVE WICHITA, KS 67207

(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 18 - Review of R4's medical revealed she moved into the facility on 08/19/21 with diagnoses of obesity and restless leg syndrome. R4's current "Functional Capacity Screen" dated 08/18/21 revealed she was unable to participate in the tasks of bathing, dressing, toileting, mobility, and management of medications and medical treatments. R4's current "Negotiated Service Agreement" (NSA) dated 08/19/21 at the top right corner included on the top right corner "Review 08/19/22" and "Review 08/19/23" with Operator/Licensed Nurse A's initials. The NSA lacked signatures of R4's legal representative for either review in 2022 or 2023. On 05/29/24 at 10:50 AM operator/Licensed Nurse A reported she did not conduct a "formal meeting" but called the legal representative about the review and any updates and they are supposed to come in and sign it. She acknowledged R4's legal representative had not signed reviews of R4's NSA. The operator failed to ensure R4's NSA was signed by everyone involved in the development of the NSA. - R5's medical record revealed she moved into the facility on 12/18/23 with diagnoses of multiple sclerosis, and anxiety disorder. R5's current "Functional Capacity Screen" dated 12/18/23 revealed R5 was unable to participate in the task of bathing, dressing, toileting, transfers, mobility, eating, and management of medications and medical treatments.	S5126		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087240	A. BUILDING: _____ B. WING _____	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE HOME PLUS LLC	400 N PETERSON AVE WICHITA, KS 67207

(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 19 R5's current "Negotiated Service Agreement" (NSA) dated 12/18/23 provided on 05/23/24 did not include the signature of the licensed nurse involved in its development. It also included on the top corner "02/19/24 update" with Operator/Licensed Nurse A's initials. The NSA failed to include the signature of the licensed nurse on 12/18/23 and the signature of R5's legal representative to indicate she was involved in the revision of R5's NSA. On 05/29/24 at 10:02 AM Operator/Licensed Nurse A acknowledged the original NSA dated 12/18/23 she forgot to sign and shd did not contact the family for signatures when she updated the NSA for wound care. The operator failed to ensure R5's NSA was signed by everyone involved in the development of the NSA.	S5126		
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 six residents (R) . Based on observation, interview, and record review for two Certified Medication Aides the	S5165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087240	A. BUILDING: _____ B. WING _____	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE HOME PLUS LLC	400 N PETERSON AVE WICHITA, KS 67207

(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 20	S5165		

operator failed to ensure the delegated nursing procedure for monitoring blood glucose via glucometer for each CMA was completed by a licensed nurse under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto prior to them checking a resident's blood sugar.

Findings included:

- R3's medical record revealed she moved into the facility on 02/21/24 with diagnoses of diabetes mellitus type II.

R3s' medical provider orders dated 02/21/24 included montoring blood sugars fasting, lunch and at dinner.

Reiew of R3's Medication Administration Record included documentation indicating Certified Medication Aide (CMA) D and CMA F had checked R3's blood sugard.

Interview on 05/23/24 at 10:47 AM CNA B reported she checked R3's insulin at lunch on the days she worked.

Interview on 05/28/24 at 05:32 PM CNA C reported sometimes she checked R3's blood sugar and writes the results on a paper for the Nurse or the CMA.

On 05/28/24 at 05:33 PM surveyor requested evidence of nurse delegation for facility staff to check R3's blood sugar.

Interview on 05/28/24 at 05:40 PM Operator/Licensed Nurse A reported she did not bring the staff in-service training to the facility and would have to get it tomorrow.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087240	A. BUILDING: _____ B. WING _____	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE HOME PLUS LLC	400 N PETERSON AVE WICHITA, KS 67207

(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 21 On 05/29/24 at 10:20 AM Operator/Licensed Nurse provided a sheet with directions on how to use a glucose monitor that included CNA B, CNA C, and CMA D's signature but did not include a nurses signature to identify the nurse had taught and delegated the procedure of checking blood sugars to the above identified certified staff. The documentation also failed to include education for CMA F to check blood sugars. The operator failed to ensure a licensed nurse delegated nursing procedure for monitoring blood glucose via glucometer was completed by a licensed nurse under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto prior to them checking a resident's blood sugar.	S5165		
S5171 SS=D	26-42-204 (i) Health Care Services Standards of Practice (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice. This REQUIREMENT is not met as evidenced by: KAR 26-42-204 (i) The facility reported a census of six residents (R). The sample included 3 residents. Based on observation, interview, and record review the operator failed to ensure all health care services were provided to residents by qualified staff in accordance with acceptable standards of practice for one (R3) of three residents related to Certified Medication Aides piercing R3's skin with her insulin pen and having the resident then push the injection button.	S5171		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087240	A. BUILDING: _____ B. WING _____	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE HOME PLUS LLC	400 N PETERSON AVE WICHITA, KS 67207

(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
S5171	Continued From page 22 Findings included: - R3's medical record revealed she moved into the facility on 02/21/24 with diagnoses of diabetes mellitus type II and hemiparesis on right side. R3's current "Functional Capacity Screen" (FCS) dated 12/16/21 identified the resident was unable to manage her medications and medical treatments. R3's current "Negotiated Service Agreement" updated on 02/13/23 identified medications were administered by CMA's and Licensed Staff. It did not specify anything differently related to insulin administration. Interview on 05/23/24 at 09:05 AM Operator/Licensed Nurse A reported there was only one resident in the facility who received insulin and she was usually here to give it the resident. Review of R3's Medication Administration Records (MAR) for Lantus Solostar insulin 12 units at bedtime revealed the following: February 2024 MAR included documentation by CMA D three times that she administered R3's insulin. April 2024 MAR included documentation by CMA D eleven times and CMA F three times for administration of R3's insulin. May 2024 MAR included documentation by CMA D 4 times that she administered R3's insulin. Interview on 05/23/24 at 09:53 AM CMA D reported R3 received insulin and staff just dial up the pen and give her the shot. CMA D clarified her statement and confirmed the CMA dialed the insulin to whatever the order is, poked the	S5171		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087240	A. BUILDING: _____ B. WING _____	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE HOME PLUS LLC	400 N PETERSON AVE WICHITA, KS 67207

(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
S5171	Continued From page 23 resident with the pen, and the resident pushed the button to give the insulin. CMA D reported Operator/Licensed Nurse A is usually here but sometimes the CMA had to give the insulin. On 05/23/24 at 02:27 PM R3 confirmed she received insulin every evening. She stated there were only three of the staff who give her insulin, Operator/Licensed Nurse A, CMA D and CMA F. R3 described administration of her insulin as staff took the pen and poked it in R3's stomach and then she pushed down on the end. On 05/28/24 at 09:37 AM Operator/Licensed Nurse A reported on one of the MAR's she noticed staff had documented they gave R3 her insulin, so she marked it error and put her initials over the CMA's. Operator/Licensed Nurse A stated the CMA is not supposed to give the insulin and could not say why they initialed they gave it or why R3 and CMA D told surveyor the CMA's had administered her insulin. The operator failed to ensure the administration of insulin, piercing of R3's skin was provided by qualified staff and in accordance with acceptable standards of practice.	S5171		
S5186 SS=F	26-42-206 (d) Dietary Services Menus (d) The menus shall be planned in advance and in accordance with the dietary guidelines adopted by reference in K.A.R. 26-39-105. This REQUIREMENT is not met as evidenced by: KAR 26-42-206 (d)	S5186		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087240	A. BUILDING: _____ B. WING _____	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE HOME PLUS LLC	400 N PETERSON AVE WICHITA, KS 67207

(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
S5186	Continued From page 24	S5186		

The facility reported a census of six residents. Based on observation and interview, the operator failed to ensure the facility menus were planned in advance, in accordance with dietary guidelines, and available to residents on a weekly basis.

Findings included:

- Observations during initial tour on 05/23/24 at 08:45 AM revealed there was no menu posted on the refrigerator or elsewhere in the kitchen or in the dining room available to residents.

On 05/23/24 at 09:20 AM Operator/Licensed Nurse A reported the menus were in the "menu" folder. She looked in the folder and acknowledge they were incomplete and said she had other menus at her home office and would bring them to the facility.

Review of the folder titled "Menus" on 05/23/24 at 09:31 AM included two undated calendars, one titled lunch and the other titled dinner. The lunch menu had 10 days with no meals planned, and what was planned included sandwich and chips, soup and crackers, fish and fries, strips and fries, with only two meals including a vegetable. The dinner menu had one day with no meals planned and nine days without a vegetable. The folder also included two weekly meal planner pages. The pagers included cereal of choice for all breakfast meals, and then one food item for lunch and dinner. Four of the days did not include a dinner item and six days did not include a lunch item.

Interview on 05/23/24 at 11:23 AM Operator/Licensed Nurse A reported she had the menus some place in all the paperwork she brought from the office and would provide as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087240	A. BUILDING: _____ B. WING _____	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE HOME PLUS LLC	400 N PETERSON AVE WICHITA, KS 67207

(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
S5186	Continued From page 25 soon as she found it. As of 05/23/24 at 04:00 PM Operator/Licensed Nurse A had not provided current menu plans that were planned according to dietary guidelines. The operator failed to ensure the facility menus were planned in advance and developed according to dietary guidelines. .	S5186		
S5192 SS=F	26-42-206 (e) Food Preparation (e) Food shall be prepared using safe methods that conserve the nutritive value, flavor, and appearance and shall be served at the proper temperature. (1) Food used by facility staff to serve to the residents, including donated food, shall meet all applicable federal, state, and local laws and regulations.(2) Food in cans that have significant defects, including swelling, leakage, punctures, holes, fractures, pitted rust, or denting severe enough to prevent normal stacking or opening with a manual, wheel-type can opener, shall not be used. (3) Food provided by a resident ' s family or friends for individual residents shall not be required to meet federal, state, and local laws and regulations. This REQUIREMENT is not met as evidenced by: KAR 26-42-206 (e) The facility reported a census of six residents. Based on record review and interview, the operator failed to ensure staff prepared food using safe methods and ensured staff prepared	S5192		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087240	A. BUILDING: _____ B. WING _____	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE HOME PLUS LLC	400 N PETERSON AVE WICHITA, KS 67207

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5192	Continued From page 26	S5192		

and served foods at the proper temperature for all residents in the facility.

Findings included:

- Review of the "Food Log" notebook on 05/23/24 at 08:45 AM revealed Food temperatures for January 2024 through current date in May 2024. The "form" included date, food category for each meal that included the entree, and other food types. For all four months every entry had the exact same temperature:
Breakfast had food temperatures for eggs at 145 degrees Fahrenheit (F), meat 165 degrees F, fruit, juice, milk, beverage were all 40 degrees F.
Lunch had food temperatures for entree 145 degrees F, starch 150 degrees, vegetables, 140 degrees F, fruit/desert, milk, beverage all read 40 degrees.
Dinner had food temperatures for entree 145 degrees F, starch 150 degrees, vegetables, 140 degrees F, fruit/desert, milk, beverage all read 40 degrees.

At the bottom of each for included directions that "meat" needed to read greater than 155 degrees F, Poultry greater than 165 degrees F, Fish/Eggs greater than 145 degrees F, cooked fruit, and vegetables greater than 140 degrees F, and cold items needed to be less than 40 degrees F.

Review of the menus in the menu folder included food items such as eggs, chicken strips, fish, chicken spaghetti, pork loin, roast, tuna salad, and other food items that need to be prepared at a specific food temperature to prevent foodborne illness and monitor potentially hazardous food temperatures.

On 05/23/24 at 08:52 AM Operator/Licensed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087240	A. BUILDING: _____ B. WING _____	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE HOME PLUS LLC	400 N PETERSON AVE WICHITA, KS 67207

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5192	Continued From page 27 Nurse A reported the temperatures in the logbook are done during the cooking process to make sure they are cooked to the proper temperatures. She said the 145 degrees F is what the foods are supposed to be cooked to so that is what temperature we put down. Operator/Licensed Nurse A looked at the directions on the bottom of the page and acknowledged the documented temperatures did not meet the directions at the bottom of the form. Review of the "Focus on Food Safety" booklet from the Kansas Department of Agriculture revised 2017 included the following food preparation critical temperature guidance: poultry, stuffed meats and pasta needed cooked to 165 degrees F, ground beef or pork needed cooked to 155 degrees F, whole muscle meat (beef, pork, fish) needed cooked to 145 degrees F, all hot foods had a minimum hot holding temperature of 135 degrees. It also included cold foods had a maximum cold holding temperature of 41 degrees F. The operator failed to ensure staff checked temperatures of food to ensure food items were cooked to the appropriate temperature.	S5192		
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	S5215		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087240	A. BUILDING: _____ B. WING _____	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE HOME PLUS LLC	400 N PETERSON AVE WICHITA, KS 67207

(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 28 procedures; (3) quarterly review of the home ' s emergency management plan with employees and residents; and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-42-104 (d)(3)(4) The facility reported a census of six residents. Based on record review and interview the operator failed to ensure disaster and emergency preparedness by the failure to conduct quarterly reviews of the home's emergency management plan quarterly with all residents and staff. Findings included: - On 05/23/24 at 09:19 AM Operator/Licensed Nurse A provided a paper titled "Fire Drill Schedule" and stated the form identified if the residents were evacuated during the drill or not. Review of the form included the month, shift, type (evacuation or not), completed (who), and actual date. Review of the 2023 form revealed the facility did an evacuation March, April, Mary, September, October, and November. However, it did not include the start time of the drill, how long it took for all residents to reach the secure location, the number of residents who participated, the number of staff who participated, or where the resident's evacuated to.	S5215		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087240	A. BUILDING: _____ B. WING _____	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE HOME PLUS LLC	400 N PETERSON AVE WICHITA, KS 67207

(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 29 Review of the 2024 form included the same information for January through May. It also lacked information as to the time the emergency drill started, how long it took for all residents to reach the secure location, the number of residents who participated, the number of staff who participated, or where the resident's evacuated to. On 05/23/24 at 09:23 AM Operator/Licensed Nurse A acknowledged the fire/emergency drill did not include information to show the actual time it took for staff to get residents to a secure location in case of an emergency. The Operator failed to ensure disaster and emergency preparedness by the failure to conduct an annual evacuation drill that identified the number of residents and how long it took to evacuate them to a secure location. - On 05/23/24 at 09:20 AM Operator/Licensed Nurse reported she did not have the quarterly reviews of the emergency management plan at the facility and must have left them at her office at home and would bring them back later today. On 05/28/24 at 03:24 PM Operator/Licensed Nurse provided nine different papers, six titled "Tornado Drill/Fire Drill and three titled "Employee Training/Staff Sign-in Sheet" which revealed the following: 04/01/23 - Tornado Drill / Fire Drill included the names of three residents and signatures of six employees. 07/01/23 - Tornado Drill / Fire Drill included the names of three residents and signatures of six employees. 11/03/23 - Tornado Drill / Fire Drill included the	S5215		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087240	A. BUILDING: _____ B. WING _____	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE HOME PLUS LLC	400 N PETERSON AVE WICHITA, KS 67207

(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 30 names of four residents and signatures of five employees. 01/15/24 - Tornado Drill / Fire Drill included the names of five residents and signatures of five employees. 01/16/24 - Employee Training / Staff Sign-in Sheet included the name of one employee. 02/11/24 - Employee Training / Staff Sign-in Sheet included the name of one employee. 04/26/24 - Employee Training / Staff Sign-in Sheet included the name of one employee. 05/12/24 - Tornado Drill / Fire Drill included the names of six residents and signatures of six employees. Interview on 05/28/24 at 03:34 PM Operator/Licensed Nurse reported she reviews all the emergency plan with all the residents and staff during a tornado and fire drill. She reviewed the forms provided and acknowledged they did not identify what was reviewed. Operator/Licensed Nurse A reported the forms with just one employee name was their initial hire on orientation. The operator failed to ensure disaster and emergency preparedness by the failure to conduct quarterly reviews of the emergency management that included all eight required potential emergencies with all residents and facility employees.	S5215		
S5246 SS=F	26-42-105 (c) Resident Record Safeguards (c) Each administrator or operator shall ensure the safeguarding of resident records against the following: (1) Loss; (2) destruction; (3) fire;	S5246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087240	A. BUILDING: _____ B. WING _____	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE HOME PLUS LLC	400 N PETERSON AVE WICHITA, KS 67207

(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
S5246	Continued From page 31 (4) theft; and (5) unauthorized use. This REQUIREMENT is not met as evidenced by: KAR 26-42-105(c)(1) The facility reported a census of six residents. The sample include three residents. Based on observation, interview for all residents, and record review the operator failed to ensure all facility resident's medical records were kept safe and free from the possibility of getting lost. Findings included: - Surveyor arrived at the facility on 05/23/24 at 08:20 AM. After completing initial tour Operator/Licensed Nurse A reported she did not keep resident records here in the facility. She takes resident records to her home office and would have to go get them in order for surveyor to complete resident medical record review. On 05/23/24 at 10:42 AM Certified Medication Aide D reported Operator/Licensed Nurse A would return to the facility in about 30 minutes and will have the resident's medical records with her. On 05/23/24 at 11:19 AM Operator/Licensed Nurse A returned to the facility with two bags full of folders and papers and a rolling cart with multiple notebooks in it. She took the notebooks (charts) out of the cart and said they were the resident records. Review of R3, R4, and R5's notebooks lacked an "Admission Agreement", "Functional Capacity Screen" (FCS), "Negotiated Service Agreement" (NSA), or a "Health Care	S5246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087240	A. BUILDING: _____ B. WING _____	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE HOME PLUS LLC	400 N PETERSON AVE WICHITA, KS 67207

(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
S5246	Continued From page 32 Service Plan" HCSP). Interview on 05/23/24 at 11:44 AM Operator/Licensed Nurse A reported she kept each residents Admission Agreement, NSA, FCS, and HCSP in a different folder and not in their "chart". At 11:49 AM Surveyor requested the folders that had the FCS, NSA, HCSP in them to review. Operator/Licensed Nurse A had papers strung out all over the kitchen bar with multiple piles and folders. Operator/Licensed Nurse A got into one of her bags and pulled out three folders and said she did not have it all together in their one chart and she would put it all together and then give to the surveyor. At 11:52 AM surveyor went back into the kitchen and explained to Operator/Licensed Nurse A the need to have resident records complete for review and she needed to get the FCS, NSA and HCSPs together for review. At 12:13 PM surveyor walked back into the kitchen and Operator/Licensed Nurse A provide surveyor files but reported she could not find all the records for some of the residents. She stated she could not find the FCS for three of the residents as well as some other assessments and resident records. At 12:35 PM Operator/Licensed Nurse reported must not have grabbed all of the files that had residents' information in them. At 12:42 PM surveyor went back into the kitchen and Operator/Licensed Nurse A continued to go through a stack of papers. She stated she still could not find the most recent FCS for three residents and thought everything else should be in the folders provided. Surveyor asked Operator/Licensed Nurse if she could get someone to cover for her so she could go to her house to find all of the resident records but she	S5246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087240	A. BUILDING: _____ B. WING _____	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE HOME PLUS LLC	400 N PETERSON AVE WICHITA, KS 67207

(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
S5246	Continued From page 33 stated she was unable to leave. Surveyor proceeded to review what records Operator/Licensed Nurse A was able to provide for R3, R4, and R5. Review of their records lacked any documentation of nursing notes from the facility nurse. R5's record did not include a completed "Functional Capacity Screen" and only included the signature page of her "Negotiated Service Agreement". On 05/23/24 at 02:51 PM surveyor requested Nursing notes for three sampled residents and Operator/Licensed Nurse A reported she "keeps them at home with other records". On 05/23/24 at 03:03 PM surveyor provided Operator/Licensed Nurse A with the regulation regarding Resident records and keeping the safeguarded against loss, fire, destruction, and unauthorized use. Operator/Licensed Nurse A acknowledged she was not organized and said "if that was a problem then go ahead and write it. The operator failed to ensure all six resident's records were maintained and safeguarded against loss and possible unauthorized use.	S5246		
S5250 SS=D	26-42-105 (f) (1 - 10) Resident Records Content (f) Each resident record shall contain at least the following: (1) The resident's name; (2) the dates of admission and discharge; (3) the admission agreement and any amendments; (4) the functional capacity screenings; (5) the health care service plan, if applicable;	S5250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087240	A. BUILDING: _____ B. WING _____	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE HOME PLUS LLC	400 N PETERSON AVE WICHITA, KS 67207

(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
S5250	Continued From page 34 (6) the negotiated service agreement and any revisions; (7) the name, address, and telephone number of the physician and the dentist to be notified in an emergency; (8) the name, address, and telephone number of the legal representative or the individual of the resident's choice to be notified in the event of a significant change in condition; (9) the name, address, and telephone number of the case manager, if applicable; (10) records of medications, biologicals, and treatments administered and each medical care provider ' s order if the facility is managing the resident's medications and medical treatments; and This REQUIREMENT is not met as evidenced by: KAR 26-42-105(f)(4)(5)(6) The facility reported a census of six residents (R). The sample included three residents. Based on record review and interview for one (R5) of three sampled residents, the operator failed to ensure R5's record contained a "Functional Capacity Screen", "Negotiated Service Agreement", and a "Health Care Service Plan". Findings included: - Review of R5's medical record revealed she moved into the facility on 12/18/23 with diagnosis of multiple sclerosis. Interview on 05/23/24 at 11:44 AM Operator/Licensed Nurse A reported she kept each residents Admission Agreement,	S5250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087240	A. BUILDING: _____ B. WING _____	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE HOME PLUS LLC	400 N PETERSON AVE WICHITA, KS 67207

(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
S5250	Continued From page 35 "Negotiated Service Agreement", "Functional Capacity Screen", and "Health Care Service Plan" in a different folder and not in their "chart". On 05/23/24 at 12:30 PM surveyor reviewed the file Operator/Licensed Nurse A provided having R5's medical record information that was not included in their chart. Review of the file revealed R5's medical record did not contain a "Functional Capacity Screen", "Negotiated Service Agreement" or a "Health Care Service Plan". Interview on 05/23/24 at 12:42 PM Operator/Licensed Nurse A acknowledged R5's file provided to surveyor did not include all of the assessments and other records and thought she just didn't grab them all from her home. As of 03:47 PM on 05/23/24 operator/Licensed Nurse A was unable to go to her home to search for the missing records that are required to be a part of a resident's record. The operator failed to ensure R5's medical record contained a Functional Capacity Screen, Negotiated Service Agreement, and a Health Care Service Plan.	S5250		
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 the date, time of occurrence, action taken, and results of the action. This REQUIREMENT is not met as evidenced	S5251		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087240	A. BUILDING: _____ B. WING _____	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE HOME PLUS LLC	400 N PETERSON AVE WICHITA, KS 67207

(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 36 by: KAR 26-42-105(f)(11) The facility reported a census of six 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 three (R3, R4, R5) of three sampled residents. Findings included: - R3 moved into the facility on 12/16/21 with diagnoses of diabetes mellitus type II, hemiparesis, and chronic obstructive pulmonary disease. R3's current "Functional Capacity Screen" dated 12/16/21 identified she needed physical assistance with all activities of daily living, unable to menage her medications or medical treatments, had impaired cognition, and at risk for falls. R3's current "Negotiated Service Agreement" reviewed on 02/13/23 revealed staff provided physical assistance with bathing, toileting, transfers, mobility and eating. Certified Medication Aides and licensed staff administered medications, needed to provide cues and simple directions and gestures related to impaired cognition. Review of R3's medical record provided on 05/23/24 at 02:00 PM lacked documentation of R3's incidents, illness, or other indications of health status concerns.	S5251		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087240	A. BUILDING: _____ B. WING _____	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE HOME PLUS LLC	400 N PETERSON AVE WICHITA, KS 67207

(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 37 On 05/23/24 at 02:51 PM Operator/Licensed Nurse A reported the Nurses Notes were not in the resident chart and she kept those in a different file at her home office. She would have to go get them but would not be able to provide them today. On 05/28/24 at 02:45 PM review of R3's medical record provided by Operator/Licensed Nurse A reported the chart now had all of R'3s medical record. The chart now included "Nurses Notes" from 10/18/22 to 01/10/23 with none of the notes including a time it was documented. The record lacked documentation related to R3's status after 01/10/23. Review of R3's physicians orders and medical providers progress notes included documentation related to antianxiety medication changes, narcotic pain medication changes, and going to the emergency room for medical treatment. It also included documentation of the resident having back surgery and going to a local rehab facility prior to return to home plus facility. On 05/29/24 at 09:39 AM operator/Licensed Nurse A reported she would document if there was a change or something going on. Operator/Licensed Nurse A stated, "as you can see I have not had time to document most things". The operator failed to ensure R3's medical record included documentation related to symptoms of illness or possible injury and any interventions that were initiated and their results. - Review of R4's medical revealed she moved into the facility on 08/19/21 with diagnoses of	S5251		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087240	A. BUILDING: _____ B. WING _____	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE HOME PLUS LLC	400 N PETERSON AVE WICHITA, KS 67207

(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 38	S5251		

obesity and restless leg syndrome.

R4's current "Functional Capacity Screen" dated 08/18/21 revealed she was unable to participate in the tasks of bathing, dressing, toileting, mobility, and management of medications and medical treatments. She also had urinary incontinence and was at risk for falls.

R4's current "Negotiated Service Agreement" dated 08/19/21 revealed staff provided physical assistance with all activities of daily living except for eating. Certified medication aides and licenses nurses administered medications and medical treatments and required hygiene assistance with urinary incontinence.

Review of R4's medical record provided on 05/23/24 at 02:05 PM lacked documentation of R4's incidents, illness, or other indications of health status concerns.

On 05/23/24 at 02:51 PM Operator/Licensed Nurse A reported the Nurses Notes were not in the resident chart and she kept those in a different file at her home office. She would have to go get them but would not be able to provide them today.

On 05/28/24 at 02:50 PM review of R4's medical record now included "Nurses Notes" from 08/19/21 to 01/10/23 with none of the notes including a time it was documented. The record lacked documentation related to resident status after 01/10/23.

R4's medical record included medical providers orders related to sending resident to ER for evaluation and treatment, readmitting to home plus, obtaining urine analysis, starting on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087240	A. BUILDING: _____ B. WING _____	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE HOME PLUS LLC	400 N PETERSON AVE WICHITA, KS 67207

(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 39	S5251		

antibiotic, starting resident on a calorie restricted diet, starting physical and occupational therapy, increase Colace and start Senna related to constipation, and treatment for right knee pain with steroid shot to be given and a topical gel for pain.

On 05/29/24 at 09:39 AM operator/Licensed Nurse A reported she would document if there was a change or something going on. Operator/Licensed Nurse A stated, "as you can see, I have not had time to document most things".

The operator failed to ensure R4's medical record included documentation related to symptoms of illness or possible injury and any interventions that were initiated and their results.

- R5's medical record revealed she moved into the facility on 12/18/23 with diagnoses of multiple sclerosis, and anxiety disorder.

R5's current "Functional Capacity Screen" dated 12/18/23 revealed R5 was unable to participate in the task of bathing, dressing, toileting, transfers, mobility, eating, and management of medications and medical treatments. She had urinary incontinence, impaired cognition and communication and impaired decision-making ability.

R5's current "Negotiated Service Agreement" dated 12/18/23 identified staff used a mechanical lift for transfers into wheelchair and provided physical assistance with all activities of daily living, including medication and treatment administration.

Review of R5's medical record provided on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087240	A. BUILDING: _____ B. WING _____	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE HOME PLUS LLC	400 N PETERSON AVE WICHITA, KS 67207

(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 40 05/23/24 at 02:07 PM lacked documentation of R5's incidents, illness, or other indications of health status concerns. On 05/23/24 at 02:51 PM Operator/Licensed Nurse A reported the Nurses Notes were not in the resident charts and she kept those in a different file at her home office. She would have to go get them but would not be able to provide them today. On 05/28/24 at 02:48 PM review of R5's medical record provided by Operator/Licensed Nurse A now included "Nurses Notes" from 12/18/23 to 01/17/24. It included one page with four entries and no time documented as to when the entry was documented. Documentation included the following: 12/18/23 - admission entry with no skin issues noted and skin intact. 01/04/24 - hydroxyzine (antihistamine) every six hours as needed for anxiety. lactulose as needed daily for constipation. 01/17/24 - increase fentanyl (narcotic pain patch) due to increased pain. R5's medical record failed to include follow-up documentation related to the above and the effectiveness of the changes, it failed to include documentation of the resident developing pressure ulcers, a licensed nurse assessment of the wounds, what staff were doing, current treatment plan and the results of the interventions/treatment plan. On 05/29/24 at 10:07 AM operator/Licensed Nurse A reported she would document if there was a change or something going on. Operator/Licensed Nurse A stated she knew she needed to work on her documentation and	S5251		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087240	A. BUILDING: _____ B. WING _____	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE HOME PLUS LLC	400 N PETERSON AVE WICHITA, KS 67207

(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 41 confirmed she did not have documentation in the chart for R5's pressure ulcers or effectiveness of changes in medications. The operator failed to ensure R5's medical record included documentation related to symptoms of illness or possible injury and any interventions that were initiated and their results.	S5251		
S5302 SS=D	26-42-205 (d) (4) Delegation of Medication Administration (4) Any licensed nurse may delegate nursing procedures not included in the medication aide curriculum to medication aides under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(d)(4) The facility reported a census of six residents(R). Based on interview and record review for two of two current "Certified Medications Aide's", revealed the operator failed to ensure a Licensed Nurse delegated the nursing procedure for dialing of insulin pens for each certified medication under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto. Findings included: - Review of the resident roster provided by Operator/Licensed Nurse A revealed one resident received insulin injections.	S5302		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087240	A. BUILDING: _____ B. WING _____	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE HOME PLUS LLC	400 N PETERSON AVE WICHITA, KS 67207

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5302	Continued From page 42 Interview on 05/23/24 at 09:05 AM Operator/Licensed Nurse A reported R3 was the only resident in the facility who received insulin and she was usually in the facility to administer it. Interview on 05/23/24 at 09:53 AM Certified Medication Aide (CMA) D reported "we just dial up the pen and give her (R3) the shot". CMA D clarified, and stated the CMA dials the pen, pokes the resident in the stomach, and them R3 will push on the end of the pen. Interview on 05/23/24 at 02:27 PM R3 confirmed she received insulin and there were only three staff who give it to her. She named Operator/Licensed Nurse A, CMA D and CMA F. She stated they take the pen and poke her stomach and then she pushes on the end of the pen. Review of R3's Medication Administration Records (MAR) revealed the following: February 2024 - CMA D initialed three time she administered R3 her Lantus insulin. March 2024 - CMA D initialed six time she administered R3 her Lantus insulin. April 2024 CMA D initialed eleven times and CMA F initialed three times she administered R3 her insulin. May 2024 - CMA D initialed four times and CMA F initialed twice that she had administered R3 her insulin. Interview on 05/29/24 at 10:15 AM Operator/Licensed Nurse A reported she had not completed delegation on preparing and dialing of an insulin pen with the CMA's. The operator failed to ensure the procedure for dialing of insulin pens was delegated to CMA's	S5302		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087240	A. BUILDING: _____ B. WING _____	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE HOME PLUS LLC	400 N PETERSON AVE WICHITA, KS 67207

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5302	Continued From page 43 according to the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto.	S5302		
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 six residents. Based on observation and interview the operator failed to ensure the home plus was designed and maintained to protect the safety of residents and the public. Findings included: - During initial tour on 05/23/24 at 09:38 AM observation revealed the facility had a front entrance and main exit door with a dead bolt that was activated and did not release with the operation of the inside door handle. On 05/23/24 at 09:41 AM Certified Nurse Aide B reported that they do use the dead bolt to lock the front door. On 05/23/24 at 09:53 AM Certified Medication	S5335		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087240	A. BUILDING: _____ B. WING _____	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE HOME PLUS LLC	400 N PETERSON AVE WICHITA, KS 67207

(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 44 Aide D confirmed the staff used the deadbolt to lock the front door and that it did not unlock automatically when the inside door handle was used. On 05/29/24 at 09:17 AM Operator/Licensed Nurse A reported she did not know the main entrance door dead bolt lock needed to release with one motion use of the inside door handle. The operator failed to ensure the safety of residents, staff, and the pubic by the failure to ensure that the main entrance and exit dead bolt lock released with one motion use of the inside door handle.	S5335		
S5355 SS=F	28-39-437 Toilet Facilities (2) Toilet facilities. (A) There shall be at least one toilet room with a lavatory, and a shower or tub, for each five individuals living in the facility. (B) The facility shall provide grab bars or equivalent assistive devices at each toilet, tub, or shower if required for resident safety. (C) Showers and tubs shall have nonslip surfaces or be provided with nonslip mats for resident safety. This REQUIREMENT is not met as evidenced by: KAR 28-39-437(e)(2)(A) The facility reported a census of six resisdents. Based on observations and interview the facility failed to ensure there was at least one toilet room	S5355		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087240	A. BUILDING: _____ B. WING _____	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE HOME PLUS LLC	400 N PETERSON AVE WICHITA, KS 67207

(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
S5355	Continued From page 45 (restroom) with a lavatory, shower or tub, for each five residents living in the facility. Findings included: - During initial tour on 05/23/24 at 08:32 AM observations included a communial restroom and and a locked door in the hall which is the "employee" restroom. Interview on 05/23/24 at 08:34 AM Operator/Licensed Nurse reported there is a second restroom but it is kept locked and for employee use only. Interview on 05/23/24 at 10:54 AM Certified Nurse Aide B confirmed there is just the one bathroom for residents to use. The operator failed to ensure the facility had sufficient restrooms available for a census of six residents.	S5355		