STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087267	A. BUILDING: _____ B. WING _____	01/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following represents the findings of a resurvey with attached complaints #192484, #192014, #190078, #188019, and #182982 at the above named home plus conducted on 01/13/25, 01/14/25, and 01/15/25.	S 000		
S 140 SS=F	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)(2) The facility reported a census of eight residents. Based on observation and interview the operator	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
	B087267	A. BUILDING: _____ B. WING _____	01/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 140	Continued From page 1 failed to ensure facility staff stored all residents' records in a private and confidential manner. Findings included: - Observation on 01/13/25 at approximately 03:05 PM revealed a cabinet with unlocked glass doors was in the common area. The cabinet contained two hospice notes books for two residents; two large notebooks labeled "ADL's" (activities of daily living) with checkoff pages for each resident; a blood pressure record book; and a notebook labeled "Caregiver Manual" for Resident (R) 6. On 01/13/25 at approximately 03:05 PM Administrative Staff B confirmed the books contained sensitive information for the residents and were not stored privately and confidentially. On 01/15/25 at approximately 12:28 PM Administrative Staff A stated the facility did not have a policy regarding protecting residents' rights for privacy and confidentiality of personal and clinical records. The operator failed to ensure facility staff stored all residents' records in a private and confidential manner.	S 140		
S 190 SS=D	26-39-102 (e) Admission, Transfer, Discharge (e) Before a resident is transferred or discharged involuntarily, the administrator or operator, or the designee, shall perform the following: (1) Notify the resident, the resident ' s legal representative, and if known, a designated family member of the transfer or discharge and the	S 190		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087267	A. BUILDING: _____ B. WING _____	01/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 190	Continued From page 2 reasons; and (2) record the reason for the transfer or discharge under any of the circumstances specified in paragraphs (d) (1) through (4) in the resident ' s clinical record, which shall be substantiated as follows: (A) The resident's physician shall document the rationale for transfer or discharge in the resident ' s clinical record if the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met by the adult care home; (B) the resident's physician shall document the rationale for transfer or discharge in the resident ' s clinical record if the transfer or discharge is appropriate because the resident's health has improved sufficiently so that the resident no longer needs the services provided by the adult care home; and (C) a physician shall document the rationale for transfer or discharge in the resident ' s clinical record if the transfer or discharge is necessary because the health or safety of other individuals in the adult care home is endangered. This REQUIREMENT is not met as evidenced by: KAR 26-39-102(e)(1)(2) The facility reported a census of eight residents with three residents included in the sample, two focused reviews and one closed record review. Based on record review and interview the operator failed to notify the appropriate persons Resident (R)1 was involuntarily discharged and	S 190		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087267	A. BUILDING: _____ B. WING _____	01/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 190	Continued From page 3	S 190		

the reasons for the discharge; failed to document the reasons for the discharge in R1's record; and failed to ensure the necessity of the discharge was substantiated by documentation of a physician provided rationale.

Findings included:

- Record review for R1 revealed an admission date of 08/10/23 with diagnoses of Alzheimer's Disease and major neurocognitive disorder with behavioral disturbance.

The 08/15/24 "Functional Capacity Screen" (FCS) identified R1 was independent with transfers and walking/mobility. He was not marked for inappropriate behavior.

The 08/15/24 "Negotiated Service Agreement" identified R1 was independent with transfers and walking/mobility.
R1's record lacked evidence of documentation of inappropriate behaviors.

R1's record lacked evidence of documentation of notification to R1 or his legal representative he was involuntarily discharged, the reasons for the discharge, and a rationale from a physician why the discharge was necessary.

The 09/21/23 "Intake Information" form to the department reported on 09/05/23, R1 was in an altercation with another resident and facility staff sent R1 to the hospital without consent from R1's guardian. The operator told them it was the facility's policy that if a resident was involved in an altercation with another resident, the resident was sent to a behavioral health unit. R1 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087267	A. BUILDING: _____ B. WING _____	01/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 190	Continued From page 4	S 190		

ready to return to the facility on 09/15/23 but the facility refused to take him back.

The 05/22/24 "Intake Information" form to the department reported R1 was taken to the hospital and was there for almost two weeks while still being charged rent at the facility. When the hospital emailed the operator to pick R1 up and take him back to the facility, she ignored the emails.

On 01/14/25 at 12:26 PM Administrative Staff A stated R1 was involved in an altercation with another resident and went to the hospital for behaviors. She did not accept him back because staff told her they would quit working if she took R1 back. Administrative Staff A confirmed R1's record failed to document his inappropriate behaviors.

On 01/15/25 at 12:01 PM Administrative Staff A stated R1 was in the hospital for two weeks. He was on a 10-day bed hold at the facility. The hospital got mad at her because she would not let R1 come back to the facility.

The facility's "Service Agreement and Contract" documented in the Bed Hold Policy section the facility would charge a bed-hold rate in addition to the regular rent from the first day of absence until the date specified in writing by the resident or responsible party.

The undated facility's "Admission, Transfer, Discharge of Residents" policy documented each resident was permitted to remain in the facility unless the facility could not meet their needs, the health or safety of other individuals was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087267	A. BUILDING: _____ B. WING _____	01/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 190	Continued From page 5 endangered, the resident failed to pay rates and charges, or the facility ceased to operate. Before the involuntary transfer occurred, the operator must notify the resident or their legal representative of the discharge including the reasons, record the reasons for the discharge in the resident's record, and ensure the necessity of the discharge was substantiated by documentation of a physician provided rationale. The operator failed to notify the appropriate persons Resident (R)1 was involuntarily discharged and the reasons for the discharge; failed to document the reasons for the discharge in R1's record; and failed to ensure the necessity of the discharge was substantiated by documentation of a physician provided rationale.	S 190		
S5055 SS=F	26-42-101 (l) Survey Report l) Survey report and plan of correction. Each administrator or operator shall ensure that a copy of the most recent survey report and plan of correction is available in a common area to residents and any other individuals wishing to examine survey results. This REQUIREMENT is not met as evidenced by: KAR 26-42-101(l) The facility reported a census of eight residents. Based on observation and interview the operator failed to ensure the most recent survey results were available in a public area. Findings included:	S5055		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087267	A. BUILDING: _____ B. WING _____	01/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5055	Continued From page 6 - Observation on 01/13/25 at approximately 01:47 PM revealed the survey results notebook sat on a shelf in the operator's office. The most recent survey results in the book was from 12/08/22. On 01/13/25 at approximately 01:47 PM Administrative Staff B confirmed the survey results notebook was not kept in a public area and did not contain the most recent survey results from 07/10/23. On 01/15/25 at approximately 12:28 PM Administrative Staff A stated the facility did not have a policy regarding ruvey results. The operator failed to ensure the most recent survey results were available in a public area.	S5055		
S5080 SS=D	26-42-201 (a) (b) Functional Capacity Screen on Admission (a) On or before each individual ' s admission to a home plus, a licensed nurse, a licensed social worker, or the administrator or operator shall conduct a screening to determine the individual ' s functional capacity and shall record all findings on a screening form specified by the department. The administrator or operator may integrate the department ' s screening form into a form developed by the home, which shall include each element and definition specified by the department. (b) A licensed nurse shall assess any resident whose functional capacity screening indicates the need for health care services.	S5080		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087267	A. BUILDING: _____ B. WING _____	01/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5080	Continued From page 7 This REQUIREMENT is not met as evidenced by: KAR 26-42-201(a)(b) The facility reported a census of eight residents with three selected for review, three for focused reviews, and one for closed record review. Based on interview and record review the operator failed to ensure designated staff conducted a screening to determine Resident (R) 7's functional capacity and that a licensed nurse assessed R7 when he required health care services. Findings included: - Record review for R7 revealed an admission date of 01/06/25 with diagnoses of dementia and night terrors. The 01/08/25 "Functional Capacity Screen" (FCS) identified R7 required physical assistance with bathing; was unable to perform management of medications and treatments; was sometimes understandable and sometimes understood others during communication; and was marked at risk for impaired vision and hearing, impaired decision-making, wandering, and inappropriate behavior. The cognition section was left blank. The "FCS" lacked evidence of documentation a licensed nursed assessed R7. He had lived in the facility seven days at the date of the survey.	S5080		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087267	A. BUILDING: _____ B. WING _____	01/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5080	Continued From page 8 R7's record lacked evidence of documentation of an "NSA." On 01/15/25 at 10:00 AM Licensed Nurse H confirmed R7 required health care services and designated staff failed to conduct a screening to determine R7's functional capacity. Licensed Nurse H also confirmed she and/or the other nurse failed to complete an assessment for R7. On 01/15/25 at approximately 12:28 PM Administrative Staff A stated the facility did not have an "FCS" policy. The operator failed to ensure designated staff conducted a screening to determine R7's functional capacity and that a licensed nurse assessed R7 when he required health care services.	S5080		
S5085 SS=D	26-42-201 (c) Functional Capacity Screen Reassessment (c) Designated staff shall conduct a screening to determine each resident ' s functional capacity according to the following requirements: (1) At least once every 365 days; (2) following any significant change in condition as defined in K.A.R. 26-39-100; and (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant. This REQUIREMENT is not met as evidenced by: KAR 26-42-201(c)(1)	S5085		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087267	A. BUILDING: _____ B. WING _____	01/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5085	Continued From page 9 The facility reported a census of eight residents with three included in the sample, three focused reviews, and one closed record review. Based on interview and record review the operator failed to ensure designated staff conducted a "Functional Capacity Screen" (FCS) for Resident (R) 6 every 365 days. Findings included: - Record review for R6 revealed an admission date of 06/30/23 with a diagnosis of quadriplegia. The 06/30/24 (most recent) "FCS" identified R6 required physical assistance with bathing, dressing, walking/mobility; was unable to perform toileting, transfers, eating, and management of medications and treatments; and was incontinent of bladder. R6's record lacked evidence of documentation of "FCS" since 06/30/24 which was 563 days at the start of the survey and 198 days late. The 06/30/23 (most recent) "NSA" identified F6 received physical assistance with bathing, dressing; assistance of two persons with mechanical lift for transfers; used a wheelchair for mobility/walking; facility staff managed medications; and a local medical service provided management of treatments. The "NSA" failed to described services provided for toileting, eating and bladder incontinence. On 01/15/25 at 11:01 AM Administrative Staff A confirmed R7's record lacked evidence of documentation of an "FCS" completed at least once every 365 days.	S5085		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087267	A. BUILDING: _____ B. WING _____	01/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5085	Continued From page 10 On 01/15/25 at approximately 12:28 PM Administrative Staff A stated the facility did not have an "FCS" policy. The operator failed to ensure designated staff completed an "FCS" for R6 every 365 days.	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; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-42-202(a)(1)(2) The facility reported a census of eight residents with three included in the sample, three focused reviews, and one closed record review. Based on interview and record review the operator failed to ensure the "Negotiated Service Agreements"	S5105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087267	A. BUILDING: _____ B. WING _____	01/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5105	Continued From page 11	S5105		

(NSAs) for Residents (R) 2, R4, and R6 described the services they received based on their "Functional Capacity Screens" (FCS) and identified the provider of the services.

Findings included:

- Record review for R2 revealed an admission date of 06/06/24 with diagnoses of venous thromboembolism and coronary artery disease

The 06/07/24 "FCS" identified R2 required physical assistance for bathing, dressing, toileting and transfers; was unable to perform walking/mobility, management of medications and treatments; and was incontinent of bladder.

The 06/07/24 "NSA" failed to describe the services R2 received for toileting, transfers, walking/mobility, management of medications and treatments, and bladder incontinence. The "NSA" also failed to identify who was responsible for providing R2 services for bathing and dressing.

On 01/15/25 at 10:19 AM Administrative Staff A confirmed the "NSA" for R2 failed to describe the services R2 received for toileting, transfers, walking/mobility, management of medications and treatments, and bladder incontinence. The "NSA" also failed to identify who was responsible for providing R2 services for bathing and dressing.

- Record review for R4 revealed an admission date of 05/01/24 with a diagnoses of calorie malnutrition and myocardial infarction.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087267	A. BUILDING: _____ B. WING _____	01/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5105	Continued From page 12 The 05/01/24 "FCS" identified R4 required physical assistance with bathing, dressing, toileting, transfers; was unable to perform transfers, eating, management of medications and treatments, was incontinent of bladder, and had short term memory and decision-making cognitive difficulties. The 07/11/24 "NSA" failed to describe the services he received for walking/mobility, eating, management of treatments, bladder incontinence, and cognitive difficulties. The "NSA" also failed to describe who was responsible for providing R4 services for bathing, dressing, toileting, and transfers. On 01/13/25 at 01:35 PM Administrative Staff B stated Certified Medication Aides (CMAs) administered food and medication to R4 through a feeding tube. On 01/15/25 at approximately 12:44 PM Administrative Staff A confirmed the "NSA" for R4 failed to describe the services he received for walking/mobility, eating, management of treatments, bladder incontinence, and cognitive difficulties. The "NSA" also failed to describe who was responsible for providing R4 services for bathing, dressing, toileting, and transfers. - Record review for R6 revealed an admission date of 06/30/23 with a diagnosis of quadriplegia. The 06/30/24 (most recent) "FCS" identified R6 required physical assistance with bathing, dressing, walking/mobility; was unable to perform toileting, transfers, eating, and management of medications and treatments; and was incontinent	S5105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087267	A. BUILDING: _____ B. WING _____	01/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5105	Continued From page 13 of bladder. The 06/30/23 (most recent) "NSA" identified R6 received physical assistance with bathing, dressing; assistance of two persons with mechanical lift for transfers; used a wheelchair for mobility/walking; facility staff managed medications; and a local medical service provided management of treatments. The "NSA" failed to described services provided for toileting, eating and bladder incontinence. The "NSA" also failed to describe who was responsible for providing R6 services for bathing and dressing. On 01/15/25 at approximately 12:28 PM Administrative Staff A stated the facility did not have an "NSA" policy. The operator to ensure the "NSAs" for R2, and R4 described the services they received based on their "FCS" and identified the provider of the services.	S5105		
S5115 SS=D	26-42-202 (c) Admission Negotiated Service Agreement (c) Each administrator or operator shall ensure the development of an initial negotiated service agreement at admission. This REQUIREMENT is not met as evidenced by: KAR 26-42-202(c) The facility reported a census of eight residents with three residents included in the sample, three focused reviews, and one closed record review.	S5115		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087267	A. BUILDING: _____ B. WING _____	01/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5115	Continued From page 14 Based on interview and record review the operator failed to ensure designated staff conducted a "Negotiated Service Agreement" (NSA) for Resident (R) 7 based on his needs and preferences on or before admission. Findings included: - Record review for R7 revealed an admission date of 01/06/25 with diagnoses of dementia and night terrors. The 01/08/25 "Functional Capacity Screen" (FCS) identified R7 required physical assistance with bathing; was unable to perform management of medications and treatments; was sometimes understandable and sometimes understood others during communication; and was marked at risk for impaired vision and hearing, impaired decision-making, wandering, and inappropriate behavior. The cognition section was left blank. R7's record lacked evidence of documentation of an "NSA." He had lived in the facility seven days at the date of the survey. On 10/20/22 at approximately 09:05 AM Administrative Staff A confirmed designated staff had not completed an "NSA" for R7. On 01/15/25 at approximately 12:28 PM Administrative Staff A stated the facility did not have an "NSA" policy. The operator failed to ensure designated staff conducted an "NSA" for R7 based on his needs and preferences.	S5115		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087267	A. BUILDING: _____ B. WING _____	01/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5116	Continued From page 15	S5116		
S5116 SS=E	26-42-202 (d) NSA revisions (d) Each administrator or operator shall ensure the review and, if necessary, revision of each negotiated service agreement according to the following requirements: (1) At least once every 365 days;(2) following any significant change in condition, as defined in K.A.R. 26-39-100; (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant; and (4) if requested by the resident or the resident ' s legal representative, staff, the case manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. This REQUIREMENT is not met as evidenced by: KAR 26-42-202(d)(1) The facility reported a census of eight residents with three residents included in the sample, three focused reviews, and one closed record review. Based on interview and record review the operator failed to ensure designated staff reviewed and if necessary, revised the "Negotiated Service Agreement" (NSA) for Resident (R) 5 and R6 every 365 days. Findings included: - Record review for R5 revealed an admission date of 01/19/22 with diagnoses of Parkinson's Disease, seizure disorder, and hemiparesis affecting the left side.	S5116		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087267	A. BUILDING: _____ B. WING _____	01/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5116	Continued From page 16 The 01/15/23 "Functional Capacity Screen" (FCS) identified R5 required physical assistance with bathing, dressing, and toileting; was unable to perform management of medications and treatments; was frequently incontinent of bladder; and was marked at risk for falls and impaired vision and hearing. R5's record lacked evidence of documentation of an "NSA." On 01/15/25 at 11:14 AM Administrative Staff B confirmed R5's record lacked evidence of documentation of an "NSA" completed at least once every 365 days. - Record review for R6 revealed an admission date of 06/30/23 with a diagnosis of quadriplegia. The 06/30/24 (most recent) "FCS" identified R6 required physical assistance with bathing, dressing, walking/mobility; was unable to perform toileting, transfers, eating, and management of medications and treatments; and was incontinent of bladder. The 06/30/23 (most recent) "NSA" identified F6 received physical assistance with bathing, dressing; assistance of two persons with mechanical lift for transfers; used a wheelchair for mobility/walking; facility staff managed medications; and a local medical service provided management of treatments. The "NSA" failed to described services provided for toileting, eating and bladder incontinence. R6's record lacked evidence of documentation of	S5116		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087267	A. BUILDING: _____ B. WING _____	01/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5116	Continued From page 17 "NSA" since 06/30/24 which was 563 days at the start of the survey and 198 days late. On 01/15/25 at 11:01 AM Administrative Staff A confirmed R7's record lacked evidence of documentation an of "NSA" completed at least once 365 days. On 01/15/25 at approximately 12:28 PM Administrative Staff A stated the facility did not have an "NSA" policy. The operator failed to ensure designated staff reviewed and if necessary, revised the "NSA" for R5 and R6 every 365 days.	S5116		
S5230 SS=F	26-42-207 (b)(5)(6) (c) Infection Control Policies (b)(5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; (c) Each administrator or operator shall ensure the home ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. This REQUIREMENT is not met as evidenced by: KAR 26-42-207(c)	S5230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087267	A. BUILDING: _____ B. WING _____	01/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5230	Continued From page 18 The facility reported a census of eight residents. Based on interview and record review the operator failed to ensure the facility remained in compliance with the department's tuberculosis (TB) guidelines for adult care homes adopted by reference in KAR 26-39-105 for three out of five sampled staff. Findings included: - Record review for Certified Medication Aide (CMA) E revealed a hire date of 07/11/24. Her record lacked evidence of documentation a TB symptom screen questionnaire and a two-step TB skin test was completed. On 01/14/25 at 02:21 PM Administrative Staff A confirmed CMA E's record lacked evidence of documentation a TB symptom screen questionnaire and a two-step TB skin test was completed. Record review for CMA F revealed a hire date of 05/07/24. Her record lacked evidence of documentation a TB symptom screen questionnaire and a two-step TB skin test was completed. On 01/14/25 at 02:03 PM Administrative Staff A confirmed CMA F's record lacked evidence of documentation a TB symptom screen questionnaire and a two-step TB skin test was completed. Record review for Certified Nurse Aide (CNA) G revealed a hire date of 12/20/23. Her record lacked evidence of documentation a TB symptom	S5230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087267	A. BUILDING: _____ B. WING _____	01/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5230	Continued From page 19 screen questionnaire and a two-step TB skin test was completed. On 01/14/25 at 01:52 PM Administrative Staff A confirmed CMA G's record lacked evidence of documentation a TB symptom screen questionnaire and a two-step TB skin test was completed. On 01/15/25 at approximately 12:28 PM Administrative Staff A stated the facility did not have a TB screening policy. The department's June 2013 "Tuberculosis (TB) Guideline for Adult Care Homes" documented each new employee shall have an TB symptom screen that includes the components of the Tuberculosis Symptom Screen Questionnaire within seven days of hire. The operator failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in KAR 26-39-105.	S5230		
S5251 SS=D	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 by:	S5251		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087267	A. BUILDING: _____ B. WING _____	01/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5251	Continued From page 20 KAR 26-42-105(f)(11) The facility reported a census of eight residents with three residents included in the sample. Based on interview and record review the operator failed to ensure designated staff provided adequate documentation when Resident (R) 2 was admitted to the hospital after a scheduled appointment with her physician and when R2 returned to the facility after a hospital stay. Findings included: - Record review for R2 revealed an admission date of 06/06/24 with diagnoses of venous thromboembolism, coronary artery disease, and hypertension. The 06/07/24 "Functional Capacity Screen" (FCS) identified R2 required physical assistance with bathing, dressing, toileting; was unable to perform walking/mobility and management of medications and treatments; and was incontinent of bladder. The 06/07/24 "Negotiated Service Agreement" (NSA) identified R2 was provided physical assistance for bathing and dressing. The "NSA" failed to describe services provided for toileting, transfers, management of medications and treatments, and bladder incontinence; and failed to identify the provider of each service. The 06/07/24 "Progress Note Observation" documented R2 admitted to the facility. The 09/01/24 "Progress Note Observation"	S5251		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087267	A. BUILDING: _____ B. WING _____	01/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5251	Continued From page 21 documented the nurse assessed R2 with normal vital signs, denied pain, no concerns. R2's record lacked evidence of documentation of signs, symptoms, actions taken, and results of the actions from 06/07/24 to 09/01/24 which was 86 days. On 01/14/25 at 04:11 PM Administrative Staff A stated last August, R2 was "not acting right." The nurse, daughter, and medical provider were notified. It was agreed to send R2 to the hospital. R2 was diagnosed with a blood clot in her leg and stayed in the hospital for three to four days. Administrative Staff A confirmed R2's record lacked evidence of documentation of signs, symptoms, including dates, times, actions taken, and results of the actions by a licensed nursing staff member when she went to the hospital and when she returned to the facility from the hospital. On 01/15/25 at approximately 12:28 PM Administrative Staff A stated the facility did not have a policy regarding nursing documentation. The operator failed to ensure designated staff provided adequate documentation when R2 was admitted to the hospital after a scheduled appointment with her physician and when R2 returned to the facility after a hospital stay.	S5251		
S5313 SS=F	26-42-205 (g) (3) Over the counter medication (g) (3) A licensed nurse or medication aide may accept over-the-counter medication only in its original, unbroken manufacturer ' s package. A licensed pharmacist or licensed nurse shall	S5313		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087267	A. BUILDING: _____ B. WING _____	01/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5313	Continued From page 22 place the full name of the resident on the package. If the original manufacturer ' s package of an over-the-counter medication contains a medication in a container, bottle, or tube that can be removed from the original package, the licensed pharmacist or a licensed nurse shall place the full name of the resident on both the original manufacturer ' s medication package and the medication container. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(g)(3) The facility reported a census of eight residents. Based on observation and interview the operator failed to ensure a licensed pharmacist or licensed nurse placed the full names of the residents on the original packages of all over-the-counter (OTC) medications. Findings included: - Observation on 01/13/25 at 11:25 AM revealed Certified Medication Aide (CMA) D unlocked and opened the medication cart. The following OTC medications were not labeled with residents' full names: Two tubes of petroleum ointment, 7 ounces (oz) One squirt bottle of Eucerin Healing Lotion, 16.9 oz One bottle of D-Mannose, 150 capsules One bottle of acetaminophen 500 milligrams (mg) 500 caplets One cardboard box of Sureprep Skin Protectant	S5313		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087267	A. BUILDING: _____ B. WING _____	01/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5313	Continued From page 23 Wipes, 50 packets One bottle of Tuck's medicated cooling pads, 100 pads Two- two-packs (four bottles) of Bausch and Lomb Bio True multi-purpose solution On 01/13/25 at approximately 11:25 AM CMA D confirmed the OTC medications were not labeled with residents' full names. On 01/15/25 at approximately 12:28 PM Administrative Staff A stated she did not have a policy for labeling OTC medications. The operator failed to ensure all OTC medications were labeled with the residents' full names.	S5313		
S5335 SS=D	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 eight residents. Based on observations, interview, and record review the operator failed to maintain the floor in	S5335		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087267	A. BUILDING: _____ B. WING _____	01/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5335	Continued From page 24	S5335		

Resident (R) 6's bedroom to protect the health and safety of R6, visitors entering his room, and any staff who provided cares for him.

Findings included:

- Record review for R1 revealed an admission date of 06/30/23 with a diagnosis of quadriplegia.

The 06/30/24 "Functional Capacity Screen" identified R6 was unable to perform transfers and required physical assistance with walking/mobility.

The 06/30/23 (most recent) "Healthcare Service Plan" (HSP) identified facility staff provided assistance with two persons using a mechanical lift for transfers and R6 used a wheelchair for walking/mobility.

Observations on 01/13/24 revealed the following:

1) The entrance to R6's room had 1.5-inch-high ledge from the common area floor to the bedroom floor at the bottom of the doorway. The ledge had dried putty applied at an angle to provide a smooth transition between the floor levels. On the left side, the putty had crumbled away which left a 4-inch gap of 1.5-inch-high ledge which posed a trip hazard.

2) The entrance to the private bathroom from the bedroom had a 1.5-inch-high ledge from the bedroom floor to the bathroom floor which posed a trip hazard. There was a metal plate on the floor in front of the ledge.

3) The flooring material in the room was peeling

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087267	A. BUILDING: _____ B. WING _____	01/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5335	Continued From page 25 up and exposed bare wood underneath in six places that measured from 1-inch long to 10 inches long. 4) In the center of room was gray duct tape applied in a straight line from one wall to the opposite wall. On 01/13/25 at approximately 09:26 AM Administrative Staff A confirmed R6's room floor was damaged. On 01/14/25 at approximately 12:28 PM Administrative Staff A stated the facility did not have a policy for maintenance or repairs. The operator failed to maintain the floor in R6's bedroom to protect the health and safety of R6, visitors entering his room, and any staff who provided cares for him.	S5335		
S5380 SS=L	28-39-437 Plumbing and Piping Systems (i) Plumbing and piping systems. (1) Backflow prevention devices or vacuum breakers shall be installed on fixtures to which hoses or tubing can be attached. (2) Water distribution systems shall be arranged to provide hot water at hot water outlets at all times. The temperature of hot water shall range between 98° F and 120° F at showers, tubs, and lavatories accessible to residents. This REQUIREMENT is not met as evidenced by: KAR 28-39-437(i)(2)	S5380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087267	A. BUILDING: _____ B. WING _____	01/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5380	Continued From page 26 The facility reported a census of eight residents. Based on observation, interview, and record review the operator failed to ensure the temperature of hot water ranged between 98 degrees Fahrenheit (F) and 120 degrees F at faucets that were accessible to all residents. This failure put all eight residents at risk for severe burns which resulted in immediate jeopardy for approximately one- and one-half months. Findings included: - Observation on 01/13/25 at approximately 09:15 AM revealed the water temperature in the bathroom 1 hall (main shower room) sink was 154.4 degrees Fahrenheit per state surveyor's thermometer. The water temperature was 151.6 degrees per the facility's thermometer. The facility had one hot water heater. All bathrooms and the kitchen in the facility were open and accessible to all the residents. On 01/13/25 at approximately 09:15 AM Administrative Staff B stated facility staff obtained a water temperature daily. The temperatures in all the facility's bathrooms ranged in the 150's for about the past one- and one-half months. On 01/13/25 at approximately 09:18 AM observed Administrative Staff B adjusted the water heater thermostat down. Review of facility provided "Water Temperature Chart" from 11/01/24 to 01/12/25 revealed facility staff logged water temperatures daily in four columns from four different locations in the facility: bathroom 1 hall, master bathroom,	S5380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087267	A. BUILDING: _____ B. WING _____	01/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5380	Continued From page 27 employee bathroom, and kitchen. 1) In November 2024 (30 days) the water temperatures above 120 degrees F in each location were as follows: a) bathroom 1 hall - 22 days b) master bathroom - 28 days c) employee bathroom - 24 days d) kitchen - 28 days 2) In December 2024 (31 days) the water temperatures above 120 degrees F in each location were as follows: a) bathroom 1 hall - 150 degrees F each day b) master bathroom - 130 degrees F each day c) employee bathroom - 130 degrees F each day d) kitchen - 150 degrees F each day 3) So far in January, to date of survey (12 days), the water temperatures above 120 degrees F in each location were as follows: e) bathroom 1 hall - 150 degrees F each day f) master bathroom - 130 degrees F each day g) employee bathroom - 130 degrees F each day h) kitchen - 150 degrees F each day Review of the facility's "Resident Roster" provided during the survey revealed all eight residents were marked for requiring assistance with ADL's. On 01/13/25 at approximately 10:07 AM Administrative Staff A stated the residents have not complained the water was too hot. Staff tested the water temperature on their wrists and adjusted the temperature of the water for the	S5380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087267	A. BUILDING: _____ B. WING _____	01/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5380	Continued From page 28	S5380		

residents to take a shower.

On 01/13/25 at approximately 10:07 AM Administrative Staff B stated staff "constantly reported" the water temperature was out of range. When the water was too hot, they adjusted the thermostat on the hot water heater and monitored the temperature for a "couple of days."

On 01/13/25 at 10:33 AM Administrative Staff A stated she had two people come out and look at the water heater, but she did not have any receipts for their work. They told her someone may be "bumping" the thermostat dial when they passed it on their way to the laundry machines. The landlord told her the water heater was new and did not need to be replaced.

Observation on 01/13/25 at 10:59 AM revealed the water heater had a manufactured date of 06/30/16.

On 01/13/25 at approximately 11:20 AM Administrative Staff A stated the water heater thermostat was last adjusted about three to four months ago when the landlord's assistant asked her brother to check the water heater.

Observation on 01/14/25 at 11:27 AM revealed the water temperature in the bathroom 1 hall was 110.8 degrees F.

Observation on 01/14/25 at 05:14 PM revealed a certified technician arrived to check the water heater.

On 01/14/25 at approximately 05:45 PM the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087267	A. BUILDING: _____ B. WING _____	01/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5380	Continued From page 29	S5380		

certified technician stated the flue to the gas-powered water heater was fine and released heat; he moved a chair away from the combustion area of the water heater; and the shut-off valve had a small constant leak which made the water heater run constantly.

The undated "Scald Injury Prevention Educator's Guide" by the American Burn Association documented older adults and people with disabilities were more likely to incur scald burn injuries from exposure to hot tap water in showers due to the following possible conditions: thinner skin; decreased sensation; mobility impairments like being prone to falls, muscle weakness, or slower reflexes; and changes in intellect, perception, memory, judgment or awareness that may hinder their ability to recognize a dangerous situation and respond appropriately.

On 01/15/25 at 12:28 PM a water temperature policy was requested. Administrative Staff A stated she did not have a water temperature policy.

Immediate jeopardy was removed on 01/15/25 at 07:25 AM when the following actions were documented by the facility in the "Abatement Plan" and accepted by the department.

1) Check water temperature at all resident accessible faucets three times a day for 48 hours.
2) The house manager or assistant would check water temperature daily to ensure it remained within a safe range.
3) Train staff to check the water temperature

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087267	A. BUILDING: _____ B. WING _____	01/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5380	Continued From page 30 when residents use the shower. 4) Certified technician checked water heater on 01/14/25. 5) Log water temperatures on a chart including date and time. 6) Call a certified technician to service water heater as needed. The operator failed to ensure the temperature of hot water ranged between 98 degrees F and 120 degrees F at faucets that were accessible to all residents which put all residents in the facility at risk for severe burns.	S5380		