STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087239	A. BUILDING: _____ B. WING _____	07/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW LIFE HOME PLUS LLC	1214 N CHARLOTTE STREET WICHITA, KS 67208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of the licensure resurvey for the above named facility conducted on 06/30/25 and 07/01/25.	S 000		
S5171 SS=E	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 7 "Residents'" (R). Based on observation, interview, and record review the Operator failed to ensure all health care services were provided to R1, R2, and R3 within accordance with acceptable standards of practice for the use of, and documentation on the use of bed assistive devices used by R's 1, 2, and 3. Findings included: - Review of the facility provided document titled "Resident Roster" revealed five out of the seven residents in the facility had a bed assist device. Record review for R1 revealed an admission date of 10/05/23 with diagnoses of anemia, type two diabetes mellitus, epilepsy, anoxic brain damage, muscle weakness, dysphagia, other lack of coordination, restlessness and agitation, aphasia, and reduced mobility.	S5171		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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S5171	Continued From page 1 R1's "Functional Capacity Screen" (FCS) dated 12/29/24 revealed R1 was unable to perform any part of the task of bathing, dressing, toileting, transferring, walking/mobility and eating. R1 lacked the ability to manage his own mediations and medical treatments. R1 was incontinent and had impaired short-term memory, long-term memory, memory /recall, and decision making. R1 was rarely or never able to make himself understood, and he rarely or never understood others. R1 was documented with socially inappropriate disruptive behavior and impaired decision making. R1 required a brace, wheelchair, and mechanical lift mobility devices. R1's FCS lacked documentation for R1 being at risk for falls, and it further lacked in the comments section of the FCS documentation of bedrails. R1's "Negotiated Service Agreement" (NSA) dated 12/29/24 identified the facility would provide two staff members to assist with bathing, dressing, and toileting. Facility staff would push R1 in his wheelchair for mobility and assist R1 with meals. Under the section titled "Health and Wellness Monitoring" in the section titled "High Risk for Falls". It was documented thar R1 was a high risk for falls due to poor balance, poor trunk control, poor safety awareness, and general weakness. R1's bed was to be in the low position with a winged mattress. R1's NSA lacked documentation of a description of the bed assist device, the purpose of the device, and any special instructions on use and monitoring of the device.	S5171		

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S5171	Continued From page 2 R1's "Health Service Plan" (HSP) instructed facility staff to provide a one-person physical assistance for feeding R1 at mealtime, manage his medications/medical treatments, and physically assist him with all "Activities of Daily Living" (ADL)'s. Under the section titled "Bathing" facility staff were instructed not to sit R1 in the "shower chair". Under the section titled "Transfer" in the plan column and "X" was documented next to the "Sit to Stand" lift. In the "Notes" column it was documented that R1 was unable to bear his own weight, and the Sit to Stand lift was to be used for all transfers. In the section titled "Mobility" in the "Notes" section it was documented R1 was dependent for repositioning in bed or chair and, "floor mat by bedside while in bed as needed". R1's HSP lacked documentation of a description of the bed assist device, the purpose of the device, and any special instructions on use and monitoring of the device. Review of R1's medical record revealed a document titled "Side Rail Rationale Screen" dated 12/27/24 revealed R1 was non-ambulatory, and he had an alteration in safety awareness due to cognitive decline. R1 had a history of falls and demonstrated poor bed mobility or had difficulty moving to a sitting position on the side of the bed. R1 was documented to have difficulty with balance and poor trunk control. R1 took mediations that required increased safety precautions, and he was currently using the side rail for positioning/support. Under the question "Has the resident expressed a desire to have side rails raised while in bed?", there was an "X" placed	S5171		

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S5171	Continued From page 3	S5171		

next to the word "yes" and handwritten under this was the Durable Power of Attorney (DPOA) due to history of seizures, and R1 had left sided weakness". In the "Comments" section it was handwritten "Resident is still using the scoop mattress and the quarter rail".

Observation on 07/01/25 at approximately 10:00 AM R1's head of the bed was located on the southeast corner of the room with the left side of the bed next to the wall. Attached on the right side of the bed was a bed assist device in the shape of a rectangle that measured approximately 32 inches in length and 13 inches high. The device was manufactured with 9 vertical post spaced approximately 2 inches apart in the center of the device to prevent any large openings in the device. Two staff members were in the room to assist R1 in getting out of bed and into the wheelchair. The quarter rail was lowered on the right side of the bed, and CMA C physically assisted R1 into a sitting position on the edge of the bed. CMA C repeatedly repositioned R1's upper body into an upright position prior to placing the belt around him for the sit to stand lift.

Interview on 07/01/24 at approximately 03:35 PM with "Registered Nurse" (RN) A and Operator B confirmed R1's DPOA wanted the bed rail in place due to the diagnoses of seizures. RN A continued to confirm the FCS lacked documentation of the quarter bedrail, and the NSA lacked documentation of a description of the bed assist device, the purpose of the device, and any special instructions on use and monitoring of the device in R1's NSA.

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S5171	Continued From page 4 - Record Review for R2 revealed an admission date of 05/09/25 with diagnoses of morbid obesity die to excess calories, Schizophrenia, Bipolar two disorder, other specified depressive episodes, generalized anxiety disorder, Undifferentiated somatoform disorder, narcissistic personality disorder, attention deficit disorder, heart failure, Raynaud's syndrome, osteoarthritis, fusion of spine lumbar region, radiculopathy, cervical region, and Klippel - Feil syndrome. R2's "Functional Capacity Screen" (FCS) dated 05/09/25 revealed R2 required physical assistance with bathing, dressing, toileting, and management of medications/medical treatments. R2 was independent with transferring, walking/mobility and eating. R2 was usually continent and had impaired short-term memory. R2 was able to make himself understood and he understood others. R2 was identified at risk for falls and socially inappropriate disruptive behavior. He used a walker and wheelchair mobility device. R2's FCS lacked documentation in the comments section of bedrails. R2's NSA dated 05/09/25 identified the R2 was independent with mobility in his electric wheelchair, and staff would assist as needed with transferring. R2's NSA lacked documentation of a description of the bed assist device, the purpose of the device, and any special instructions on use and monitoring of the device.	S5171		

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S5171	Continued From page 5 R2's "Health Service Plan" (HSP) dated 05/09/25 in the section titled "Mobility" it was documented that R1 was free to go out as needed by signing the registry, and under the column titled "Notes" it was documented that R2 had a history of falls and used a walker when ambulating. R2's HSP lacked documentation of a description of the bed assist device, the purpose of the device, and any special instructions on use and monitoring of the device. Review of R2's medical record revealed a document titled "Side Rail Rational Screen" dated 05/29/25 that identified the bed assist device was used to enable R2 with transfers and bed mobility to promote independence. Observation on 07/01/25 at approximately 03:20 PM, R2's bed was located in the northwest corner of the room with the head of the bed next to the north wall and the right side of the bed was next to the wall. Attached to the right side of the bed was a bed assist device that was in the shape of an "L" and was pivoted in the upright position. The device measured approximately 27 inches in length and 10 inches in height. There device was manufactured with a bar in the center of the device with an approximate 4-inch space on each side of the bar to prevent any large openings in the device. Interview on 07/01/25 at approximately 03:20 PM with R2 confirmed the bed assist device was raised and lowered as needed and he further confirmed that he used the device to assist him in getting in and out of the bed.	S5171		

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S5171	Continued From page 6 Interview on 07/01/25 at approximately 03:35 PM with RN A confirmed the comments section of R2's FCS lacked the documentation of the bed assist device, RN A further confirmed R2's NSA lacked documentation of a description of the bed assist device, the purpose of the device, and any special instructions on use and monitoring of the device in R2's NSA. - Record review for R3 revealed an admission date of 05/13/22 with diagnoses of diabetes mellitus type two, unspecified dementia, unspecified psychosis, major depressive disorder, and non-rheumatic aortic valve stenosis. R3's FCS dated 06/04/25 revealed R3 was unable to perform any part of the task of bathing, dressing, toileting, transferring, walking/mobility, and she required physical assistance with eating. R3 lacked the ability to manage her own mediations and medical treatments. R3 was incontinent and had impaired short-term memory, long-term memory, memory /recall, and decision making. R3 was sometimes able to make herself understood, and she sometimes understood others. R3 was documented at risk for falls, having impaired vision, socially inappropriate disruptive behavior, and impaired decision making. R3 required a wheelchair, and mechanical lift mobility devices. R3's FCS lacked documentation in the comments section of bedrails. R3's NSA dated 06/04/25 identified facility staff	S5171		

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S5171	Continued From page 7 would provide physical assistance of one to two staff for bathing, dressing, toileting, and transferring with the mechanical lift. Under the section titled "Mobility/Walking" int was documented that R3 had a high back wheelchair that staff would push for mobility, and "repositioning-physical assistance with positioning". It was documented that R3 would lean to the left, right, or forward due to poor core strength when sitting up. R3 was to be positioned with "bolsters on side or pillows for positioning". Under the section titled "Health and Wellness Monitoring" it was documented R3 was at a "High Risk for Falls: Unsteadiness" R3 was a high risk for falls due to poor balance, general weakness, and neuropathy in her legs. R3 used a wheelchair, full mechanical lift, floor mat and mat alarm, bed was to be in the lowest position. R3's NSA lacked documentation of a description of the bed assist device, the purpose of the device, and any special instructions on use and monitoring of the device. R3's HSP dated 06/04/25 instructed facility staff would provide a two person assist with bathing and transferring. Under the section titled "Mobility" in the "Notes" column it was documented "Bed mobility- repositioning assistance, floor mat alarm by bedside while in bed". R3's HSP lacked documentation of a description of the bed assist device, the purpose of the device, and any special instructions on use and monitoring of the device.	S5171		

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S5171	Continued From page 8 Review of R3's medical record revealed a document titled "Side Rail Rationale Screen" dated 05/13/22, there was an "X" placed next to the statement that read "Side rails do not appear to be indicated at this time." Observation on 07/01/25 at approximately 03:05 PM of R3's bed revealed the left side of the bed was against the west wall of the room with the head of the bed against the south wall. Attached to the right side of the bed was bed assist device in the shape of a rectangle that measured approximately 32 inches in length and 13 inches high. The device was manufactured with 9 vertical post spaced approximately 2 inches apart in the center of the device to prevent any large openings in the device. Interview on 07/01/25 at approximately 03:35 PM with RN A and Operator B confirmed the medical record for R3 lacked documentation of the following assessments being performed for R3; an assessment to ensure the bed assist was not a restraint, an assessment to determine the purpose of the device and R3's ability to safely use the device, and an assessment to ensure the device was securely attached to the bed or bedframe and posed no risk for entrapment. RN A continued to confirmed R3's FCS lacked documentation of the bed assist device in the comments section, and RN A further confirmed R3's NSA lacked a description of the device, its purpose, and any special on use and monitoring of the device, and R3's medical record lacked documentation of periodic reassessments R3's use of the device and of R3's ability to safely use the device.	S5171		

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S5171	Continued From page 9 Review of the undated facility policy titled "Bed Rail/Bed Assist Device Policy" revealed the following: An assessment would be done upon admission, annually and with noted significant changes to ensure the devices continued to serve the purpose and pose no risk for entrapment or restraint. The resident would be assessed for the risk of entrapment and the risk and benefits of the bedrails. Based on the assessment, an individual care plan would be developed. The care plan would detail the need for the bedrail and the potential risks. The bedrails/bed assist devices would be properly installed, maintained, and regularly inspected by the licensed staff to ensure safety. "The description, the purpose and any special instructions on use and monitoring of the bedrail/bed assist device will be included in the Negotiated Service Plan/Health Care Plan and Functional Capacity Screen". The FDA (food and drug administration) "Bedrails in Assisted Living, Residential Health Care and Home Plus Facilities" recommended the following: Complete an assessment of the resident to confirm that the device is not a restraint. Complete an assessment of the resident to	S5171		

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S5171	Continued From page 10 determine the purpose of the device and the resident's ability to safely use the device and document the findings in the resident's record. Complete an assessment of the device using the recommendations in the FDA guidance to ensure the device is securely attached to the bed or bedframe and poses no risk for entrapment and document the findings in the resident record. If the purpose of the device is to assist the resident with transfers, the FCS should document the resident's functional capacity based on the use of the device and should be listed in the comments section. Include a description of the device, its purpose and special instructions on use and monitoring in the resident's NSA. Document periodic reassessments of the resident's use of the device and their ability to use it safely and reassessment of the safety of the device in the resident's record. The Operator failed to ensure all health care services were provided to R1, R2, and R3 within accordance with acceptable standards of practice for the use of, and documentation on the use of bed assistive devices used by R's 1, 2, and 3.	S5171		
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:	S5215		

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S5215	Continued From page 11 (1) Orientation of new employees at the time of employment to the home ' s emergency management plan; (2) education of each resident upon admission to the home regarding emergency procedures; (3) quarterly review of the home ' s emergency management plan with employees and residents; and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-42-104 (d) (3) The facility reported a census of 7 "Residents'" (R). Based on record review and interview the Operator failed to ensure the quarterly review of the facility's emergency management plan with all staff and residents. Findings included: - Review of the facility provided document titled "Fire Drill Record" revealed there was a fire drill on 01/10/25 and 04/08/25. Review of the facility provided document titled "Tornado Drill Record" revealed there was a tornado drill performed on 01/20/25 and 04/04/25. Review of the facility provided document titled "Emergency Response Procedures Manual"	S5215		

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S5215	Continued From page 12 revealed the facility administrator was responsible for ensuring employees and residents receive appropriate training regarding response to emergency situations, and the Administrator was responsible for ensuring appropriate and complete documentation of employee and resident training regarding "emergency situations are in place". Interview on 06/30/25 at approximately 03:00 PM with Operator B confirmed he provided monthly meetings with all staff and residents and the nine emergency preparedness topics are covered. Operator B further confirmed he did not have documentation showing which employees and residents were present at the monthly meetings. The Operator failed to ensure the quarterly review of the facility's emergency management plan with all staff and residents.	S5215		
S5286 SS=D	26-42-205 (b) Administration of Selected Medications (b) Administration of select medications. Any resident who self-administers medication may select some medications to be administered by a licensed nurse or medication aide. The negotiated service agreement shall reflect this service and identify who is responsible for the administration and management of selected medications. This REQUIREMENT is not met as evidenced by: KAR 26-42-205 (b)	S5286		

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S5286	Continued From page 13 The facility reported a census of 7 "Residents'" (R). Based on interview and record review the Operator failed to ensure the "Negotiated Service Agreement" (NSA) for R2 identified who was responsible for the administration and management of R2's Albuterol Inhaler. Findings included: - Record Review for R2 revealed an admission date of 05/09/25 with diagnoses of morbid obesity die to excess calories, Schizophrenia, Bipolar two disorder, other specified depressive episodes, generalized anxiety disorder, Undifferentiated somatoform disorder, narcissistic personality disorder, attention deficit disorder, heart failure, Raynaud's syndrome, osteoarthritis, fusion of spine lumbar region, radiculopathy, cervical region, and Klippel - Feil syndrome. R2's "Functional Capacity Screen" (FCS) dated 05/09/25 revealed R2 required physical assistance with bathing, dressing, toileting, and management of medications/medical treatments. R2 was independent with transferring, walking/mobility and eating. R2 was usually continent and had impaired short-term memory. R2 was able to make himself understood and he understood others. R2 was identified at risk for falls and socially inappropriate disruptive behavior. He used a walker and wheelchair mobility device. R2's NSA dated 05/09/25 identified the facility would provide medication management by the	S5286		

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S5286	Continued From page 14	S5286		

"Licensed Nurse" (LN) and "Certified Medication Aide" (CMA). "All medication and treatments will be kept in the medication cart and given by the nurse or CMA daily as ordered by the physician."

R2's "Health Service Plan" (HSP) dated 05/09/25 in the section titled "Medications" in the column titled "Plan" an "X" was documented next to "Self-Administered" and "Administered By Staff". In the column titled "Plan" it was documented the CMA or nurse would administer all medication, and R2's medications were kept in the medication cart, and "inhaler at bedside".

Review of R2's medical record revealed a document titled "Self-Administration of Medications Assessment" dated 05/09/25 revealed R2 could safely and without staff assistance self-administer the Albuterol inhaler. In the Medications Approved section it was documented that the Albuterol inhaler was at the bedside.

Review of R2's medical record revealed a document titled "Home Health Certification and Plan of Care" dated 04/02/25 for the certification period of 04/06/25 to 06/04/25, that revealed an order for Albuterol Sulfate Hydrofluoroalkane (HFA) 108 (90) base micrograms/actuation 2 puffs every 4 hours as needed for shortness of air.

Interview on 07/01/25 at approximately 03:20 PM with R2 confirmed he keeps in the inhaler in his unlocked nightstand drawer.

Interview on 07/01/25 at approximately 05:35 with "Registered Nurse" (RN) A and Operator B

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087239	A. BUILDING: _____ B. WING _____	07/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW LIFE HOME PLUS LLC	1214 N CHARLOTTE STREET WICHITA, KS 67208

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S5286	Continued From page 15 confirmed R2 kept his Albuterol inhaler at the bedside and that he did self-administer the inhaler as directed when needed. RN A further confirmed R2's NSA lacked identification of the select medication kept at the bedside for self-administration. Review of the undated facility provided policy titled Self-Administration of Medication revealed the resident self-administration assessment would be filed in the clinical record, and the record would contain the assessment and determination. The policy lacked the instruction of the NSA reflecting the identification of who was responsible for select medications. The Operator failed to ensure the NSA for R2 identified who was responsible for the administration and management of R2's Albuterol Inhaler.	S5286		
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 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.	S5313		

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S5313	Continued From page 16 This REQUIREMENT is not met as evidenced by: KAR 26-42-205 (g) (3) The facility reported a census of 7 "Residents'" (R). Based on interview and record review the Operator failed to ensure the "Licensed Nurse" (LN) or the Licensed Pharmacist placed the full name of the resident on the bottles of "Over-the-Counter" medications. Findings included: - Observation on 07/01/25 at approximately 09:35 AM "Certified Medication Aide" (CMA) C unlocked the facility medication cart located in the northwest corner of the dining room revealed the following; In the second drawer down the following OTC medications which lacked the full name of the resident; 1 bottle of Pain Reliver Acetaminophen 500 milligram (mg) with "CR" written on the cap of the bottle. 1 bottle of Magnesium 400 mg with "CR" written on the cap of the bottle. 1 bottle of Melatonin 3 mg with "CR" written on the cap of the bottle. 1 bottle of Folic Acid 400 micrograms In the third drawer down the following OTC medication which lacked the full name of the	S5313		

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S5313	Continued From page 17 resident; 1 bottle of D-Mannose 500 mg Review of the undated facility policy titled "OTC Medication" revealed "3. All medication containers will be labeled with the resident's full name for identification." Interview on 07/01/25 at approximately 03:30 PM with "Registered Nurse" (RN) A and Operator B confirmed all OTC medications were to be labeled with the resident's full name. The Operator failed to ensure the LN or the Licensed Pharmacist placed the full name of the resident on the bottles of OTC medications.	S5313		