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	B087268	A. BUILDING: _____ B. WING _____	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE HOME PLUS	6321 E PEACH TREE LANE WICHITA, KS 67218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citation represents the findings of a Re-Licensure Survey with complaint investigations 195200 and 196458 for the above named facility conducted on 08/11/25, 08/12/25 and 08/13/25.	S 000		
S 140 SS=D	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 eight residents (R). The sample include three residents and one	S 140		

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

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S 140	Continued From page 1	S 140		

focused record review. Based on observations and interview, the operator failed to ensure staff provided one (R3) of three sampled residents privacy while providing personal care.

Findings included:

- Review of R3's medical record revealed she moved into the facility on 10/01/24 with a diagnosis of vascular dementia.

Interview on 08/13/25 at 10:15 AM Administrative Nurse /Operator A and Administrative Licensed Nurse B reported the "Functional Capacity Screen", "Negotiated Service Agreement", and the "Health Care Service Plan' were considered one combines document (FCS/NSA/HCSP).

R3's FCS/NSA/HCSP dated 04/01/25 revealed she was unable to participate in bathing, dressing, toileting, and mobility and she had impaired cognition. It identified R3 required assistance of staff for dressing, assist of 1-2 staff for transfers, and staff assisted resident with making simple daily decisions.

Interview on 08/11/25 at 01:27 PM Certified Medication Aide (CMA) F reported R3 usually needed total assistance for cares including transferring and dressing.

Observation on 08/12/24 at 08:04 AM Certified Medication Aide (CMA) G and CMA H went in to get R3 out of bed. R3's room mate laid in the bed on the other side of the room awake and had full view of the care staff provided to R3. CMA G pulled down the covers and explaining it was time to get up and then they proceeded to

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S 140	Continued From page 2 provide incontinent care while her roommate had full view of this process. When staff had finished dressing her lower body, they helped her to sit on the side of the bed and transferred her into her wheelchair facing toward the direction of her room mate. CMA H then removed R3's night gown and put on a blouse. This process allowed R3 to be exposed to her room mate from her waist up without any clothing on. Interview on 08/12/25 at 08:20 AM Administrative Nurse/Operator A reported all of the semi-private rooms had divider screens staff were supposed to use when providing personal care. The operator failed to ensure staff provided privacy for R3 while providing personal care.	S 140		
S5026 SS=D	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)(C) The facility reported a census of eight residents.	S5026		

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S5026	Continued From page 3 The sample included 3 residents (R) and one focused record review. Based on interview and record review the operator failed to ensure R2 was not subjected to exploitation related to facility staff stealing an article of R2's clothing. Findings included: - Review of R2's medical record revealed she moved into the facility on 02/05/24 with persistent atrial fibrillation. Interview on 08/13/25 at 10:15 AM Administrative Nurse/Operator A and Administrative Licensed Nurse B reported the "Functional Capacity Screen", "Negotiated Service Agreement", and the "Health Care Service Plan' were considered all one document (FCS/NSA/HCSP). R2's "FCS/NSA/HCSP" dated 01/28/25 revealed R2 required physical assistance with allk activities of daily living including dressing. She had impaired cognition and stfaf were to allow her to make simple decisions regarding what she was to wear and eat. Review of the facility investigation revealed that CMA E saw CNA D, previous employee, wearing R2's sweatshirt that had been reported missing. Administrative Nurse/Operator checked camera observations which comfirmed on 04/18/25 CMA D had on R2's sweatshirt. R2's family was notified and confirmed it was R2's sweatshirt. Aministrative Nurse/Operator A attempted to speak with CNA D about the sweater and CNA D refused to speak with her. At that point, Administrative Nurse/Operator A went to the police department to fill out a police repor	S5026		

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S5026	Continued From page 4 regarding the stolen sweatshirt. For R2, the operator failed to ensure she was not subjected to exploitation when CNA D was discovered to have stolen the resident's sweatshirt..	S5026		
S5080 SS=F	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. This REQUIREMENT is not met as evidenced by: KAR 26-42-201(a) The facility reported a census of eight residents (R). The sample included three residents and one focused record review. Based on record review for three (R3, R4, R5) of three sampled	S5080		

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S5080	Continued From page 5 residents and interview for all residents, the operator failed to ensure the "Functional Capacity Screen" included each element and definition as specified by the department. Findings included: - Review of R3's medical record revealed she moved into the facility on 10/01/24 with a diagnosis of vascular dementia. Interview on 08/13/25 at 10:15 AM Administrative Nurse/Operator A and Administrative Licensed Nurse B reported the "Functional Capacity Screen", "Negotiated Service Agreement", and the "Health Care Service Plan' were considered one combines document (FCS/NSA/HCSP). R3's FCS/NSA/HCSP dated 10/01/24 failed to include a section for staff to identify the resident's functional ability related to medical treatments. - Review of R4's medical record revealed he moved into the facility on 01/31/24 with diagnosis of multiple sclerosis. Interview on 08/13/25 at 10:15 AM Administrative Nurse/Operator A and Administrative Licensed Nurse B reported the "Functional Capacity Screen", "Negotiated Service Agreement", and the "Health Care Service Plan' were considered one combines document (FCS/NSA/HCSP). R4's FCS/NSA/HCSP dated 03/22/25 failed to include a section for staff to identify the resident's functional ability related to medical treatments.	S5080		

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S5080	Continued From page 6 - Review of R5's medical record revealed he moved into the facility on 07/11/25 with diagnosis of persistent atrial fibrillation. Interview on 08/13/25 at 10:15 AM Administrative Nurse/Operator A and Administrative Licensed Nurse B reported the "Functional Capacity Screen", "Negotiated Service Agreement", and the "Health Care Service Plan' were considered one combines document (FCS/NSA/HCSP). R4's FCS/NSA/HCSP dated 03/22/25 failed to include a section for staff to identify the resident's functional ability related to medical treatments. Interview on 8/12/25 at 03:30 PM Administrative Licensed Nurse B reported the medical treatments were under the "Ordered Therapies and Treatment" section. Administrative Licensed Nurse B reviewed the FCS/NSA/HCSP form and confirmed it did not include a place for the licensed nurse to assess and code the resident's functional ability to manage medical treatments. Administrative Licensed Nurse B reported all residents had the same format for the functional capacity screen. The operator failed to ensure the "Functional Capacity Screen" section of the FCS/NSA/HCSP included each element and definition in their form as specified by the department related to management of medical treatments.	S5080		
S5085 SS=D	26-42-201 (c) Functional Capacity Screen Reassessment	S5085		

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S5085	Continued From page 7 (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)(2) The facility reported a census of eight residents(R). The sample included three residents and one focused record review. Based on observation, interview, and record review the operator failed to ensure designated staff completed a resident "Functional Capacity Screen" for one (R3) of three sampled residents following a significant change in condition as defined in KAR 26-39-100. Findings Included: - Review of R3's medical record revealed she moved into the facility on 10/01/24 with a diagnosis of vascular dementia. Interview on 08/13/25 at 10:15 AM Administrative Nurse /Operator A and Administrative Licensed Nurse B reported the "Functional Capacity Screen", "Negotiated Service Agreement", and the "Health Care Service Plan' were one combined document (FCS/NSA/HCSP).	S5085		

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S5085	Continued From page 8 R3's record included a FCS/NSA/HCSP dated 09/30/24 that identified R3 needed physical assistance with bathing, dressing, toileting, and supervision with transfers, walk/mobility, and eating. Review of R3's nursing progress notes from 11/21/24 to 02/30/25 facility staff documented R3 needed increased assistance with cares, would not assist with transfers or put weight on her legs. She could not walk and started using a wheelchair for mobility. Staff also documented they had to crush her medications and feed her as she would not feed herself. Interview on 08/13/25 at 09:54 AM Administrative Licensed Nurse B acknowledged R3 had a significant decline in status from November to February of 2025 and she should have completed a new FCS/NSA/HCSP due to the decline. The operator failed to ensure designated staff completed a new FCS section of R3's FCS/NSA/HCSP when she had a decline in her functional ability related to completion of activities of daily living.	S5085		
S5095 SS=E	26-42-201 (d) Functional Capacity Screen Accurate (d) Designated staff shall ensure that each resident ' s functional capacity at the time of screening is accurately reflected on that resident ' s screening form.	S5095		

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S5095	Continued From page 9 This REQUIREMENT is not met as evidenced by: KAR 26-42-201(d) The facility reported a census of eight residents(R). The sample include three residents and one focused record review. Based on observation, interview, and record review the operator failed to ensure designated staff completed two (R3, R4) of three sampled resident's "Functional Capacity Screen" accurately to reflect the resident's functional ability to participate in activities of daily living. Findings Included: - Review of R3's medical record revealed she moved into the facility on 10/01/24 with a diagnosis of vascular dementia. Interview on 08/13/25 at 10:15 AM Administrative Nurse /Operator A and Administrative Licensed Nurse B reported the "Functional Capacity Screen", "Negotiated Service Agreement", and the "Health Care Service Plan' were one combined document (FCS/NSA/HCSP). R3's FCS/NSA/HCSP dated 04/01/25 revealed she was unable to participate in walking/mobility, needed physical assistance with eating an management of medications. It identified R3 could not walk but it took 1-2 staff to transfer her, she used a wheelchair, and at risk for falls as she would scoot herself out of a recliner at times. Observation on 08/11/25 at 12:53 PM facility staff and spouse assisted her to eat her lunch. R3 did	S5095		

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S5095	Continued From page 10	S5095		

not assist in eating her meal.

Observation on 08/12/24 at 08:04 AM Certified Medication Aide (CMA) G and CMA H assisted R3 to transfer out of her bed and into her wheelchair and then pushed her via wheelchair into the dining and up to the table for breakfast.

Interview on 08/11/25 at 01:27 PM CMA F reported R3 is totally dependent on staff for everything including eating and mobility. She uses a wheelchair to get from place to place but cannot propel herself.

Interview on 08/12/25 at 03:23 PM CMA F reported staff crush R3's medications and mix them in chocolate syrup and give it to her in a spoon.

Interview on 08/13/25 at 09:27 AM Administrative Licensed Nurse B reported she coded mobility a three because the resident did not walk and on occasion, she could feed herself. After reviewing the FCS manual confirmed she had coded R3's FCS section wrong according to the manual.

The operator failed to ensure designated staff completed the FCS accurately for R3 related to walk/mobility, eating, and management of medications.

- Review of R4's medical record revealed he moved into the facility on 01/31/24 with a diagnosis of multiple sclerosis.

Interview on 08/13/25 at 10:15 AM Administrative Nurse /Operator A and Administrative Licensed Nurse B reported the "Functional Capacity

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S5095	Continued From page 11	S5095		

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

R4's FCS/NSA/HCSP dated 03/22/25 identified he needed supervision with dressing, unable to participate in walk/mobility and required supervision in management of medications. It also identified staff helped R4 with buttons, zippers and took one to two staff assistance with pulling up his pants. It also directed staff that he used a wheelchair for mobility and could propel himself once in the chair. Licensed Nurse and Certified Medication Aides prepared and administered R4's.

Observation on 08/11/25 at 01:33 PM resident propelled himself from where he at his lunch over to the living room and watched TV. He then told staff he wanted to go outside, and he propelled himself over to the front door, staff opened the door and helped him to go outside, and staff came back inside.

Interview on 08/11/25 at 01:30 PM Certified Medication Aide F reported R4 was pretty much dependent on staff for cares. Staff get his bottom half dressed and he can dress his upper body with his shirt at times. It takes one - two staff to help him transfer into his wheelchair but he can propel himself where he wants to go. CMA F also reported staff administered all R4's medications.

Interview on 08/13/25 at 10:20 AM Administrative Licensed Nurse B confirmed she had not coded R4's FCS section correctly and R4 was not supervision but needed physical assistance with

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S5095	Continued From page 12 cares. The operator failed to ensure designated staff completed R4's FCS section accurately related to walk/mobility, dressing, and management of medications.	S5095		
S5116 SS=D	26-42-202 (d) NSA revisions (d) Each administrator or operator shall ensure the review and, if necessary, revision of each negotiated service agreement according to the following requirements: (1) At least once every 365 days;(2) following any significant change in condition, as defined in K.A.R. 26-39-100; (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant; and (4) if requested by the resident or the resident ' s legal representative, staff, the case manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. This REQUIREMENT is not met as evidenced by: KAR 26-42-202(d)(2) The facility reported a census of eight residents(R). The sample included three residents and one focused record review. Based on interview, and record review the operator failed to ensure designated staff reviewed and revised, if necessary, the "Negotiated Service Agreement" for one (R3) of three sampled residents following a significant change in	S5116		

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S5116	Continued From page 13 condition as defined in KAR 26-39-100. Findings Included: - Review of R3's medical record revealed she moved into the facility on 10/01/24 with a diagnosis of vascular dementia. Interview on 08/13/25 at 10:15 AM Administrative Nurse /Operator A and Administrative Licensed Nurse B reported the "Functional Capacity Screen", "Negotiated Service Agreement", and the "Health Care Service Plan' were one combined document (FCS/NSA/HCSP). R3's record included a FCS/NSA/HCSP dated 09/30/24 that identified R3 needed physical assistance with bathing, dressing, toileting, and supervision with transfers, walk/mobility, and eating. Review of R3's nursing progress notes from 11/21/24 to 2/30/25 facility staff documented R3 needed increased assistance with cares, would not assisting with transfers or put weight on legs. She could not walk and started using a wheelchair for mobility. Staff documented they also had to crush her medications and having to feed her as she would not feed herself. Interview on 08/13/25 at 09:54 AM Administrative Licensed Nurse B acknowledged R3 had a significant decline in status from November to February of 2025 and she should have completed a new FCS/NSA/HCSP due to the decline. The operator failed to ensure designated staff	S5116		

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S5116	Continued From page 14 reviewed and revised the NSA section of R'3s FCS/NSA/HCSP when she had a decline in her functional ability related to completion of activities of daily living.	S5116		
S5141 SS=D	26-42-203 (c) Respite Care Services (c) Respite care services. Any administrator or operator of a home plus may provide respite care services to individuals who meet the home's admission and retention criteria on a short-term basis if the administrator or operator ensures that the following conditions are met: (1) Written policies are developed and procedures are implemented for the provision of respite care services. (2) All the requirements for admission of a resident to a home plus are met for an individual admitted for respite care services. This REQUIREMENT is not met as evidenced by: KAR 26-42-203(c)(2) The facility reported a census of 8 residents(R) . The sample included three residents with one having received "Respite" services in the past year. Based on record review and interview the operator failed to ensure designated staff completed an admission agreement for "Respite Care". Findings included: - Review of R3's medical record revealed she moved into the facility on 09/13/24 for respite care services and discharged on 09/19/24. On	S5141		

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	B087268	A. BUILDING: _____ B. WING _____	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE HOME PLUS	6321 E PEACH TREE LANE WICHITA, KS 67218

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S5141	Continued From page 15 10/02/24 R3 moved into the facility to stay with a diagnosis of vascular dementia. R3's record included a "Functional Capacity Screen" and a "Negotiated Service Agreement" dated 09/13/24 but did not include an admission agreement. Interview on 08/13/25 at 09:59 AM Administrative Nurse/Operator confirmed she had not completed an admission agreement for when R3 stayed at the facility for short periods of time for respite care. The operator failed to ensure the requirement for completion of an admission agreement to move into a home plus was also completed for a resident who planned on a short stay for respite services.	S5141		
S5225 SS=E	26-42-207 (a) (b) (1)(2)(3)(4) Infection Control a) The administrator or operator of each home plus shall ensure the provision of a safe, sanitary, and comfortable environment for residents. (b) Each administrator or operator shall ensure the development of policies and implementation of procedures to prevent the spread of infections. These policies and procedures shall include the following requirements: (1) Using universal precautions to prevent the spread of blood-borne pathogens; (2) techniques to ensure that hand hygiene meets professional health care standards; (3) techniques to ensure that the laundering and handling of soiled and clean linens meet professional health care standards;	S5225		

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S5225	Continued From page 16 (4) providing sanitary conditions for food service; This REQUIREMENT is not met as evidenced by: KAR 26-42-207(b)(1) The facility reported a census of eight residents(R). The sample included three residents and one focused record review. Based on observation, interview and record review the operator failed to ensure certified staff followed proper infection control measures related to management of catheters for two (R4,R5) of three sampled residents. Findings included: - Review of R4's medical record revealed he moved into the facility on 01/31/24 with diagnosis of multiple sclerosis. Interview on 08/13/25 at 10:15 AM Administrative Nurse/Operator A and Administrative Licensed Nurse B reported the "Functional Capacity Screen", "Negotiated Service Agreement", and the "Health Care Service Plan' were one combined document (FCS/NSA/HCSP). R4's FCS/NSA/HCSP dated 03/22/25 identified R4 required assistance of 1-2 staff for transfers and assist of one with dressing. It also identified R4 had a suprapubic catheter with facility staff to provide care and empty every shift. Observation on 08/13/25 at 08:10 AM Certified Medication Aide (CMA) F and CMA I went in to transfer resident from his bed to wheelchair.	S5225		

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S5225	Continued From page 17 Resident's left knee was bent and would not straighten. As CMA I sat resident up in the bed the catheter bag slid across the floor and then CMA F hooked the bag onto the wheelchair. Interview on 08/13/25 at 08:25 AM Administrative Nurse/Operator confirmed catheter bags were not to be touching the floor related to infection control. The operator failed to ensure certified staff followed proper infection control measure related to management of R4's catheter. - Review of R5's medical record revealed he moved into the facility on 07/11/25 with diagnosis of persistent atrial fibrillation. Interview on 08/13/25 at 10:15 AM Administrative Nurse/Operator A and Administrative Licensed Nurse B reported the "Functional Capacity Screen", "Negotiated Service Agreement", and the "Health Care Service Plan' were considered one combines document (FCS/NSA/HCSP). R5's FCS/NSA/HCSP identified he needed assistance of one staff for dressing and assist of 1-2 staff for transfers. It also identified R5 had an indwelling catheter with staff to provide catheter care and empty every shift. Observation on 08/11/25 at 01:03 PM resident propelled self from dining room into his room and his catheter bag was hooked under his wheelchair and drug across the floor. Observation at 01:13 PM R5 started to get himself into bed pushing on the mattress setting	S5225		

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S5225	Continued From page 18 off the alarm. Certified Medication Aide (CMA) F went in to assist R5 and unhooked the catheter bag, put it on top of the bed which was higher than R5's bladder, completed a pivot transfer to help R5 onto the bed. After CMA F got R5 comfortable he hooked the catheter bag to the bed frame which left the bag/spicket touching the floor. Interview on 08/13/25 at 08:25 AM Administrative Nurse/Operator confirmed catheter bags were not to be touching the floor related to infection control. The operator failed to ensure certified staff followed proper infection control measure related to management of R5's indwelling catheter.	S5225		
S5313 SS=D	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. This REQUIREMENT is not met as evidenced by:	S5313		

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S5313	Continued From page 19 KAR 26-42-205(g)(3) The facility reported a census of eight residents (R). Based on observation and interview the operator failed to ensure a licensed pharmacist or CMA accepted over-the-counter medications in their original, unbroken manufactures package. Findings included: - On 08/11/25 at 10:23 AM Certified Medication Aide C unlocked the medication cart for inspection. In the top drawer was a pill bottle that had white pills in it. It included a resident's name handwritten with black marker and "Tylenol 500 mg (milligrams) every 4 hours prn (as needed)". Interview on 08/11/25 at 10:56 AM Administrative Licensed Nurse B reported she kept a couple empty bottles to use for medications family brought in that do not come in a box or container. Interview on 08/11/25 at 11:15 AM Administrative Nurse/Operator A reported medications needed to be in the original container and could not be in a plain pharmacy type bottle. The operator failed to ensure each over-the-counter medication was accepted in it original manufacturer package.	S5313		