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 _____	09/24/2025

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 citations represent the findings of an abbreviated survey for complaints #196976 & 19637 at the above named facility conducted on 09 23/25 & 09/24/25.	S 000		
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: K.A.R.26-42-202 (a) (1) (2) (3) The facility reported a census of 7 residents. The sample included 1 "Resident" (R). Based on interview and record review the Operator failed to ensure the "Negotiated Service Agreement" (NSA) for R1 provided a description of services the resident would receive, identification of the provider of each service, and identification of	S5105		

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 _____	09/24/2025

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 1 each party responsible for payment when an outside resource was used. Findings included: - Record review for R1 revealed an admission date of 07/31/25 with diagnoses of type two diabetes mellitus, major depressive disorder, heart failure and r3estless and agitation. Review of R1's "Functional Capacity Screen" (FCS) dated 08/07/25 revealed R1 required supervision with bathing, dressing, transferring and walking/mobility. R1 required physical assistance with toileting. R1 lacked the ability to manage his own medications/medical treatments. R1 was incontinent and his cognition was intact. R1 was able to make himself understood and he understood others. R1 was documented at risk for falls, impaired hearing, and socially inappropriate disruptive behavior. R1 used prothesis and wheelchair mobility devices. Review of R1's combined NSA/"Health Service Plan" (HSP) dated 08/07/25 under the section titled "Health Care Services" the facility would manage R1's medications and handwritten was "Resident to give self insulin". Review of R1's electronic "Medication Administration Record" (eMAR) revealed the following order; Insulin Glargine 100 units/milliliter (3milliliter) (100 unit/milliliter (3 milliliter)) Interview on 09/24/25 at approximately 09:53 AM	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 _____	09/24/2025

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 2 with Operator A and outside provider "Registered Nurse" (RN) B confirmed the outside provider RN administers R1's insulin injections daily. The Operator failed to ensure the "Negotiated Service Agreement" (NSA) for R1 provided a description of services the resident would receive, identification of the provider of each service, and identification of each party responsible for payment when an outside resource was used.	S5105		