STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087254	A. BUILDING: _____ B. WING _____	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ULTRA CARE HOME PLUS LLC 3	1532 S CREEKSIDE CT WICHITA, KS 67230

(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 represent the findings of a resurvey for the above named Home Plus facility conducted on 11/25/25.	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: KAR 26-42-202(a)(1) 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 the "Negotiated Service Agreement" (NSA) was fully developed based on the resident's "Functional Capacity Screen" (FCS), service needs, and preferences for resident (R)101 and R103.	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
	B087254	A. BUILDING: _____ B. WING _____	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ULTRA CARE HOME PLUS LLC 3	1532 S CREEKSIDE CT WICHITA, KS 67230

(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 Findings included: - R101's medical record revealed she moved into the facility on 10/16/21 with a diagnosis of dementia. The 08/25/25 FCS identified R101 was unable to manage medical treatments on her own. The 08/25/25 NSA did not address R101's management of medical treatments. On 11/25/25 at 02:50 PM Administrative Nurse A confirmed R101's FCS triggered for management of treatments. Administrative Nurse A stated R101 did not receive any treatments at this time and confirmed the NSA did not address the management of treatments. The operator failed to ensure R101's NSA was fully developed to include all items that triggered in the FCS. - R103's medical record revealed she moved into the facility on 06/05/25 with a diagnosis of Parkinson's Disease. The 07/10/25 FCS identified R103 triggered for inappropriate behaviors. The 07/10/25 NSA did not address what interventions staff implanted to address R103's inappropriate behaviors. The 06/06/25 "Observation Note" documented, "Staff reports that resident has been highly	S5105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087254	A. BUILDING: _____ B. WING _____	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ULTRA CARE HOME PLUS LLC 3	1532 S CREEKSIDE CT WICHITA, KS 67230

(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 disruptive. She has been yelling constantly and hitting the table and wall. Verbal aggression has been directed to staff and other residents. She states, "It's good that I am causing chaos and disturbing others, I don't want to be here." She has...been very difficult to redirect. Other residents in the facility are now complaining." The 08/16/25 "Observation Note" documented R103 was still yelling for her sister that had passed away and still banged on the walls or tables at times. On 11/25/25 at 02:56 PM Administrative Nurse A stated R103's NSA did not directly address inappropriate behaviors of yelling and banging on the table and wall. The operator failed to ensure R103's NSA was fully developed to include all items that triggered in the FCS.	S5105		