STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087201	A. BUILDING: _____ B. WING _____	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOVING HEARTS LLC	2311 W WESTPORT ST WICHITA, KS 67203

(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 with attached complaint numbers 197439, 195131, 192723, and 188525, for the above named facility conducted on 12/23/25.	S 000		
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: K.A.R. 26-42-205 (g) (3) The facility reported a census of 5 residents. The sample included 3 "Residents'" (R)'s. Based on observation and interview the Operator failed to ensure all "Over the Counter" (OTC) medications contained the resident's full name. Findings Included:	S5313		

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
	B087201	A. BUILDING: _____ B. WING _____	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOVING HEARTS LLC	2311 W WESTPORT ST WICHITA, KS 67203

(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 1 - Observation on 12/23/25 at approximately 10:20 AM during the facility tour, in the southeast bathroom in a closed cabinet above the toilet was a tube of Calmoseptine that lacked the full name of the resident. Interview on 12/23/35 at approximately 04:30 PM with Operator A confirmed all OTC's bottles, tubes and containers, were to contain the full name of the resident. The Operator failed to ensure all OTC medications contained the resident's full name.	S5313		
S5335 SS=F	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: K.A.R. 28-39-437 (a) The facility reported a census of 5 residents. The sample included 3 "Residents'" (R)'s. Based on observation and interview the Operator failed to ensure the home was maintained to protect the health and safety of all residents.	S5335		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087201	A. BUILDING: _____ B. WING _____	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOVING HEARTS LLC	2311 W WESTPORT ST WICHITA, KS 67203

(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 2 Findings Included: - Observation on 12/23/25 at approximately 10:20 AM during the facility tour in the northeast hall closet, in the southwest corner of the closet, was a portable type E oxygen tank, that was in a cardboard box and was leaning with the regulator of the device against the wall. Sitting next to the box were two, two wheeled tilt portable oxygen cylinder carts. On the shelfs on the north side of the closet were one bottle of Equate nail polish remover, and one bottle of 100% Acetone nail polish remover. In the bathroom on the southwest side of the home, on the shower floor was a dirty and wet washcloth. In the southeast corner of the home a door separated the laundry area from the kitchen. The door was opened and on the north wall was the washer and dryer. The cabinets above the washer were unlocked and freely opened sat a large container of laundry soap. On the island on the northwest side of the kitchen sat a container of Sani wipes. Interview on 12/23/25 at approximately 04:30 PM with Operator A confirmed all chemicals should be secured and all oxygen cylinders were to be stored in the cylinder holders provided. The Operator failed to ensure the home was maintained to protect the health and safety of all residents.	S5335		