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	B087277	A. BUILDING: _____ B. WING _____	01/08/2026

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CENTRAL CARE PLUS LLC	629 LONGFELLOW STREET WICHITA, KS 67207

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S 000	INITIAL COMMENTS The following represent the findings of a resurvey for the above named Home Plus facility conducted on 01/08/26.	S 000		
S 110 SS=F	26-39-103 (c) NOTICE OF RIGHTS AND SERVICES (c) Notice of rights and services. (1) Before admission, the administrator or operator shall ensure that each resident or the resident's legal representative is informed, both orally and in writing, of the following in a language the resident or the resident ' s legal representative understands: (A) The rights of the resident; (B) the rules governing resident conduct and responsibility; (C) the current rate for the level of care and services to be provided; and (D) if applicable, any additional fees that will be charged for optional services. (2) The administrator or operator shall ensure that each resident or the resident ' s legal representative is notified in writing of any changes in charges or services that occur after admission and at least 30 days before the effective date of the change. The changes shall not take place until notice is given, unless the change is due to a change in level of care. This STANDARD is not met as evidenced by: 0110 KAR 26-39-103(c)(1)(C) The facility reported a census of two residents. Based on interview and record review the	S 110		

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

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S 110	Continued From page 1 operator failed to ensure Resident (R)101 and R102 were informed, both orally and in writing of the current rate for the level of care and services to be provided. Findings included: - R101 was admitted to the facility on 11/21/25 with a diagnosis of dementia. Review of R101's medical records failed to locate documentation that she was informed of the rate she would be charged for the level of care and services to be provided by the facility. On 01/08/26 at 02:34 PM Administrative Nurse A stated R101's Admission Agreement did not include the rate for services provided. The operator failed to ensure R101was informed both orally and in writing of the current rate for the level of care and services to be provided to him by the facility. - R102 was admitted to the facility on 12/05/25 with a diagnosis of dementia. Review of R102's medical records failed to locate documentation that she was informed of the rate she would be charged for the level of care and services to be provided by the facility. On 01/08/26 at 02:49 PM Administrative Nurse A stated R102's Admission Agreement did not include the rate for services provided. The operator failed to ensure R102 was informed	S 110		

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S 110	Continued From page 2 both orally and in writing of the current rate for the level of care and services to be provided to him by the facility.	S 110		
S5105 SS=F	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: 5105 KAR 26-42-202(a)(1) The facility reported a census of eight residents with two 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 R102.	S5105		

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S5105	Continued From page 3 Findings included: - R101's medical record revealed she moved into the facility on 11/21/25 with a diagnosis of dementia. The 11/21/25 FCS identified R101 required physical assistance with toileting, and eating, was unable to manage her treatments, experienced occasional incontinence, was rarely or never understandable and was only sometimes understood. The 11/21/25 NSA did not address the services staff provided R101 concerning toileting, eating, incontinence, management of treatments, and communication. On 01/08/26 at 02:34 PM Administrative Nurse A confirmed that not all that triggered on R101's FCS was addressed on the NSA. The operator failed to ensure R101's NSA was fully developed to include all items that triggered in the FCS, her service needs, and preferences. - R102's medical record revealed she moved into the facility on 12/05/25 with a diagnosis of dementia. The 12/05/25 FCS identified R102 was unable to manage her own medical treatments and was sometimes understandable and sometimes understood others. The 12/05/25 NSA did not address what services	S5105		

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S5105	Continued From page 4 staff provided R102 concerning management of medical treatments and communication. On 01/08/26 at 02:49 PM Administrative Nurse A confirmed that not all that triggered on R102's FCS was addressed on the NSA. The operator failed to ensure R102's NSA was fully developed to include all items that triggered in the FCS, her service needs, and preferences.	S5105		
S5126 SS=F	26-42-202 (h) NSA Signatures (h) Each individual involved in the development of the negotiated service agreement shall sign the agreement. The administrator or operator shall ensure that a copy of the initial agreement and any subsequent revisions are provided to the resident or the resident's legal representative. This REQUIREMENT is not met as evidenced by: 5126 KAR 26-42-202(h) The facility had a census of two residents. Both residents were included in the sample. The operator failed to ensure each individual involved in the development of the "Negotiated Service Agreement" (NSA) signed the agreement for Resident (R)101, and R102. Findings included: - R101's medical record revealed she moved into	S5126		

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S5126	Continued From page 5 the facility on 11/21/25 with a diagnosis of dementia. The 11/21/25 "Functional Capacity Screen" (FCS) revealed R101 had severe cognitive impairment. The 11/21/25 NSA was not signed by R101's legal representative. On 01/08/26 at 02:34 PM Administrative Nurse A confirmed R101's NSA was not signed by her legal representative. The operator failed to ensure R101's NSA was signed by her legal representative. - R102's medical record revealed she moved into the facility on 12/05/25 with a diagnosis of dementia. The 12/05/25 FCS revealed R102 had severe cognitive impairment. The 12/05/25 NSA was not signed by R102's legal representative. On 01/08/26 at 02:49 PM Administrative Nurse A confirmed R102's NSA was not signed by her legal representative. The operator failed to ensure R102's NSA was signed by her legal representative.	S5126		
S5161 SS=F	26-42-204 (d) Health Care Services (d) The negotiated service agreement shall contain a description of the health care services	S5161		

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S5161	Continued From page 6 to be provided and the name of the licensed nurse responsible for the implementation and supervision of the plan. This REQUIREMENT is not met as evidenced by: 5161 KAR 26-42-204(d) The facility reported a census of two residents with both residents included in the sample. Based on interview and record review the operator failed to ensure the "Negotiated Service Agreement" (NSA) identified the licensed nurse responsible for the implementation and supervision of the health care services plan for Resident (R)101 and R102. Findings included: - R101's medical record revealed she moved into the facility on 11/21/25 with a diagnosis of dementia. The 11/21/25 "Functional Capacity Screen" (FCS) revealed R101 had severe cognitive impairment. R101's most recent NSA was completed upon admission to the facility on 11/21/25 failed to identify the licensed nurse responsible for the implementation and supervision of the health care services. On 01/08/26 at 02:34 PM Administrative Nurse A confirmed R101's NSA did not identify the nurse	S5161		

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S5161	Continued From page 7 responsible was not identified. The operator failed to ensure the NSA was updated to identify the licensed nurse responsible for the implementation and supervision of the health care services plan for R101. - R102's medical record revealed she moved into the facility on 12/05/25 with a diagnosis of dementia. The 12/05/25 FCS revealed R102 had severe cognitive impairment. R102's most recent NSA was completed upon admission to the facility on 12/05/25 failed to identify the licensed nurse responsible for the implementation and supervision of the health care services. On 01/08/26 at 02:49 PM Administrative Nurse A confirmed R102's NSA did not identify the nurse responsible was not identified. The operator failed to ensure the NSA was updated to identify the licensed nurse responsible for the implementation and supervision of the health care services plan for R102.	S5161		
S5210 SS=F	26-42-104 (b) Written Emergency Plan b) Each administrator or operator shall ensure the development of a detailed written emergency management plan to manage potential emergencies and disasters, including the following:	S5210		

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S5210	Continued From page 8 (1) Fire; (2) flood; (3) severe weather; (4) tornado; (5) explosion; (6) natural gas leak; (7) lack of electrical or water service; (8) missing residents; and (9) any other potential emergency situations. This REQUIREMENT is not met as evidenced by: 5210 KAR 26-42-104(b)(8) The facility reported a census of two residents. Based on record review and interview for all residents and all facility employees, the operator failed to ensure the disaster and emergency plan include all required items as it failed to include information concerning missing residents. Findings included: - On 01/08/26 review of the emergency management plan revealed it did not include information concerning missing residents. On 01/08/26 at approximately 11:40 AM Administrative Nurse A confirmed there was no information concerning missing residents included in the facility's emergency management plan. The operator failed to ensure the emergency management plan included all the required	S5210		

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S5210	Continued From page 9 items.	S5210		
S5230 SS=F	26-42-207 (b)(5)(6) (c) Infection Control Policies (b)(5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; (c) Each administrator or operator shall ensure the home ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. This REQUIREMENT is not met as evidenced by: 5320 KAR 26-42-207(c) The facility reported a census of two residents at the time of the initial certification survey. Based on interview and record review the operator failed to ensure the facility remained in compliance with the department's tuberculosis (TB) guidelines for adult care homes adopted by reference in KAR 26-39-105. Findings included: - Resident (R) R101 admitted to the facility on	S5230		

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S5230	Continued From page 10 11/21/25 with a diagnosis of dementia. Review of R101's medical records revealed she the first step of the two-step TB skin test (TST) was read as negative on 11/26/25. There was no evidence the second step of the TST was administered. On 01/08/26 at 02:34 PM Administrative Nurse A confirmed the second step of the TST was not completed for R101. The June 2013 "Tuberculosis (TB) Guidelines for Adult Care Homes" documented, "If the first TST is read as not positive, a second TST shall be administered within 1 to 3 weeks." The operator failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in KAR 26-39-105 regarding newly admitted residents. - R102 was admitted to the facility on 12/05/25 with a diagnosis of dementia. Review of R102's medical records revealed there was no documentation of a two-step TST administered within seven days of admission to the facility. On 01/08/26 at 02:49 PM Administrative Nurse A stated the TST for R102 was not completed upon admission because she had this completed at another facility but stated they did not have this documentation on file. The June 2013 "Tuberculosis (TB) Guidelines for	S5230		

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S5230	Continued From page 11 Adult Care Homes" documented, "Each new resident ...shall receive a two-step TST or an IGRA for Mycobacterium tuberculosis within 7 days of residency ...unless one of the following conditions is met: ...The new resident ...provide satisfactory documentation of receiving the two-step TST or AGRA within 6 months prior to residency ..." The operator failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in KAR 26-39-105.	S5230		
S5313 SS=E	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: 5313 KAR 26-42-205(g)(3) The facility reported a census of two residents.	S5313		

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S5313	Continued From page 12 Based on observation and interview the operator failed to ensure a licensed pharmacist or licensed nurse placed the full name of the resident on the original package of over-the-counter medications (OTC). Findings included: - Observation on 01/08/26 at 09:47 AM of the medication cart revealed the following OTC medications that were not labelled with the resident's full name: Two bottles of Kroger Melatonin 5 milligrams Two bottles of Kroger Vitamin D3 One bottle of Kroger Gas Relief One bottle of Kroger Laxative Powder One bottle of Geri-Lanta Antacid and Anti-gas The operator failed to ensure all over-the-counter medications were labeled with the resident's full name.	S5313		
S5315 SS=F	26-42-205 (h) Medication Storage (h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s recommendations or those of the pharmacy provider and with federal and state laws and regulations. (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the home in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the home in	S5315		

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S5315	Continued From page 13 separately locked compartments within a locked medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals. (2) Each resident managing and self-administering medication shall store medications in a place that is accessible only to the resident, licensed nurses, and medication aides. (3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy provider may request that the medication be stored by the home. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration. This REQUIREMENT is not met as evidenced by: 5315 KAR 26-42-205(h)(1) The facility reported a census of two residents. Based on observation and interview the operator failed to ensure resident medications were securely stored and failed to ensure only licensed nurses and medication aides had access to the stored medications and biologicals. Findings included: - Observation on 01/08/26 at 09:47 AM "Certified	S5315		

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S5315	Continued From page 14 Nurse Aide" (CNA) B had access to the keys that unlocked the medication cart while the operator was not at the facility. The medication cart contained numerous medications, both supplied by the pharmacy and "Over the Counter" (OTC) medications for both residents. On 01/08/26 at 09:50 AM CNA B verified that she was only a CNA and was not a Certified Medication Aide. On 01/08/26 at 10:02 AM an observation of the north restroom revealed there was a container of Nystatin powder that belonged to R102 that was not properly secured in a locked medication cart. On 01/08/26 at 10:55 AM Administrative Nurse A confirmed that the keys to the medication cart were left unsecured and were accessible to all staff. The operator failed to ensure medications were securely stored to ensure only licensed nurses and medication aides had access to stored medications.	S5315		
S5320 SS=F	26-42-205 (k) Medication Clinical Records (k) Clinical record. The administrator or operator, or the designee, shall ensure that the clinical record of each resident for whom the home manages the resident ' s medication or prefills medication containers or syringes contains the following documentation: (1) A medical care provider ' s order for each medication; (2) the name of the pharmacy provider of the resident ' s choice;	S5320		

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S5320	Continued From page 15 (3) any known medication allergies; and (4) the date and the 12-hour or 24-hour clock time any medication is administered to the resident. This REQUIREMENT is not met as evidenced by: 5320 KAR 26-42-205(k)(4) The facility reported a census of two residents with both residents included in the sample. Based on record review and interview the facility failed to ensure the clinical record of each resident for whom the facility administered medications for contained the 12-hour or 24-hour clock time any medications were administered to residents. Findings included: - Review of the medication administration records for Resident (R)101 and R102 revealed administration times of medications were labeled with "AM" (morning), "PM" (evening) and "HS" (bedtime) instead of using a 12-hour or 24-hour clock time. On 01/08/26 at 02:34 PM Administrative Nurse A confirmed the medication administration records for R101 and R102 did not have a 12- or 24-hour format for the times medications were administered.	S5320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087277	A. BUILDING: _____ B. WING _____	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S5320	Continued From page 16 The operator failed to ensure the clinical records for medication administration included a 12 or 24-hour clock time.	S5320		
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: 5335 KAR 28-39-437 (a) The facility reported a census of two residents. Based on observation the operator failed to ensure staff secured all chemicals to maintain the safety of all residents. Findings included: - Observations during initial tour on 01/08/26 revealed the following unlocked chemicals not properly stored to prevent access by residents who had severely impaired cognition: An observation on 01/08/26 at 09:45 AM of the south bathroom revealed a 24 fluid (fl.) ounce	S5335		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087277	A. BUILDING: _____ B. WING _____	01/08/2026

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S5335	Continued From page 17 (oz.) bottle of Lysol Power Cleaning gel with a "KEEP OUT OF REACH OF CHILDREN" warning label. An observation on 01/08/26 at 09:57 AM revealed an unlocked cabinet located above the dryer that had the following chemicals with a "KEEP OUT OF REACH OF CHILDREN" warning label: One 12 fl. oz. container of Minwax Wood Filler One box of Clorox Toilet Wand cleaning refills An observation on 01/08/26 at 10:08 AM of the kitchen revealed the following chemicals with a "KEEP OUT OF REACH OF CHILDREN" warning label located in a cabinet underneath the kitchen sink: One 75 oz. bottle of Great Value Automatic Dishwasher Gel One eight oz. spray can of Great Value Linen Fresh Air Freshener One 19 oz. spray can of Lysol Disinfectant spray One box of Seventh Generation Power Dishwasher Detergent Packs The operator failed to ensure staff kept chemicals were securely locked for the safety of residents and visitors.	S5335		