KANSAS DEPARTMENT FOR AGING AND DISABILITY SERVICES
SURVEY, CERTIFICATION AND CREDENTIALLING COMMISSION

LICENSE OR PROVIDERS NO.		DATE OF VISIT
B087220	Resurvey- 7WYB11	03/31/26
NAME OF FACILITY	STREET, ADDRESS, CITY, STATE, ZIP CODE	
Ultra Care Home Plus	11537 E. Harry Street, Wichita, KS 67207	

ITEM	COMMENTS
	No comments Thank you
	THE SIGNATURES BELOW ACKNOWLEDGE DISCUSSION OF THE DIFICIENCY LIST, THE RECEIPT OF A COPY OF THE SAME AND THE RECEIPT OF INFORMATION ABOUT THE BUREAU'S *"INFORMAL DISPUTE RESOLUTION"* PROCESS.

DATE	SURVEYOR'S SIGNATURE	FACILITY REPRESENTATIVE'S SIGNATURE	DATE
03/31/26	Chris Peppel, RN/HFS	[signature]	03/31/26

COMMENT SHEET

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087220	A. BUILDING _____ B. WING _____	03/31/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ULTRA CARE HOME PLUS	11537 E. HARRY STREET WICHITA, KS 67207

(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 represents the findings of a resurvey at the above named Home Plus facility conducted on 03/31/26 which resulted in no citations.	S 000		

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

Radem 3/31/26