STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087162	A. BUILDING: _____ B. WING _____	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ULTRA CARE HOME PLUS 4	14601 E TIMBER LAKE ROAD 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 complaint investigations #197079 and 197090 at the above named Home Plus conducted on 03/31/26 and 04/01/26.	S 000		
S5028 SS=D	26-42-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the home as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation.	S5028		

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

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S5028	Continued From page 1 This REQUIREMENT is not met as evidenced by: 5028 KAR 26-42-101(f)(3)(C) The facility reported a census of eight residents with two residents included in the sample and one closed record review. Based on interview and record review the operator failed to report an allegation of abuse, neglect, or exploitation to the department within 24 hours, failed to thoroughly investigate this incident, and failed to submit a report to the department within five working days of the initial report to the department. Findings included: - Record review for Resident (R)101 revealed she moved into the facility on 05/09/22 with a diagnosis of dementia. The 07/11/25 "Functional Capacity Screen" (FCS) identified R101 required physical assistance with transfers and mobility. The 07/11/25 "Negotiated Service Agreement" (NSA) originally identified R101 required the use of a Hoyer lift for transfers but was changed to R101 required the use of a sit-to-stand lift. An entry dated 10/16/24 on R101's care plan documented R101 required two-person assist with transfers using a sit-to-stand lift. An undated witness statement written by "Certified Nurse Aide" (CNA) C documented she	S5028		

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S5028	Continued From page 2 noticed R101 avoided standing with her right leg when trying to put her in a wheelchair using a sit-to-stand lift and noticed that R101's right thigh was swollen. On 04/01/26 at 11:56 AM Administrative Nurse A stated she obtained a written witness statement from the staff who reported R101 had a swollen thigh. Administrative Nurse A stated she also questioned the other staff on duty the morning of the incident as well as staff who worked on the previous shift who laid R101 down for the night, but said she failed to get written witness statements from these staff. Administrative Nurse A was unable to determine the cause of R101's injury and stated R101 had a history of pathological fractures in the past and suspected this was the cause of R101's current injury. Department records show no email or phone reports regarding this incident. The operator failed to report an allegation of abuse, neglect, or exploitation to the department within 24 hours of the incident, failed to complete a thorough investigation of the incident, and failed to submit a final report of this incident to the department within five days of the initial report of the incident.	S5028		
S5251 SS=D	26-42-105 (f) (11) Resident Records Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action.	S5251		

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S5251	Continued From page 3 This REQUIREMENT is not met as evidenced by: 5251 KAR 26-42-105(f)(11) The facility reported a census of eight residents. The sample included two residents and one closed record review. Based on record review and interview the operator failed to ensure documentation in accordance with accepted professional standards and practices including all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken and results of the action for Resident (R)101. Findings included: - Record review for Resident (R)101 revealed she moved into the facility on 05/09/22 with a diagnosis of dementia. The 07/11/25 "Functional Capacity Screen" (FCS) identified R101 required physical assistance with transfers and mobility. The 07/11/25 "Negotiated Service Agreement" (NSA) originally identified R101 required the use of a Hoyer lift for transfers but was changed to R101 required the use of a sit-to-stand lift. The 09/21/25 "Observation Note" documented care staff reported R101 experienced pain to her right lower extremity while staff attempted to transfer R101 using a sit-to-stand lift. R101's	S5251		

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S5251	Continued From page 4 primary care provider, the hospice nurse and R101's durable power of attorney (DPOA) were notified. The DPOA requested that R101 be sent to the hospital for an evaluation and treatment. There was no further documentation to be found in R101's medical record to show what the cause of R101's leg pain was, what treatments she received and what the final outcome was for R101. On 03/31/26 at 02:30 PM Administrative Nurse A stated R101 was sent to the hospital but never returned as she was transferred to a skilled nurse facility. Administrative Nurse A confirmed there was no other nursing notes in R101's medical record after she was transferred to the hospital on 09/21/25. The operator failed to ensure documentation for R101's care was in accordance with accepted professional standards and practices.	S5251		