STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087231	A. BUILDING: _____ B. WING _____	04/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMANI HOME PLUS	1201 N PINECREST ST WICHITA, KS 67208

(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 a Re-Licensure Survey for the above named Home Plus Facility conducted on 04/27/26.	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)(2) The facility reported a census of eight residents(R). The sample included three residents. Based on interview, and record review for three (R3, R4, R5) of three sampled residents the operator failed to ensure designated staff developed a "Negotiated Service Agreement" based on the resident's "Functional Capacity Screen" and service needs, which include the	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
	B087231	A. BUILDING: _____ B. WING _____	04/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMANI HOME PLUS	1201 N PINECREST ST WICHITA, KS 67208

(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 name of the provider for podiatry services. Findings included: - Review of R3's medical record revealed she moved into the facility on 10/06/23 with a diagnosis of dementia. R3's "Functional Capacity Screen" dated 01/09/26 revealed she needed physical assistance with all activities of daily living and could not manage her medications. R3's "Negotiated Service Agreement", titled "Negotiated Service/Health Care Plan" (NSA/HCP) dated 01/09/26 identified she received podiatry services but failed to identify the provider of the service. Interview on 04/27/26 at 02:55 PM Operator/Nurse reported she did not realize she needed to include in the NSA/HCP "who" provided the service. The operator failed to ensure designated staff completed R3's NSA/HCP to include the provider of R3's podiatry service. - Review of R4's medical record revealed he moved into the facility on 04/25/25 with a diagnosis of diabetes mellitus type II. R4's "Functional Capacity Screen" dated 04/25/25 identified he needed physical assistance with activities of daily living and could not manage his medications and medical treatments.	S5105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087231	A. BUILDING: _____ B. WING _____	04/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMANI HOME PLUS	1201 N PINECREST ST WICHITA, KS 67208

(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 R4's "Negotiated Service Agreement", titled "Negotiated Service/ Health Care Plan" (NSA/HCP) dated 04/25/25 identified he received podiatry services but did not identify the provider of the service. Interview on 04/27/26 at 02:55 PM Operator/Nurse reported she did not realize she needed to include in the NSA/HCP "who" provided the service. The operator failed to ensure designated staff completed R4's NSA/HCP to include the provider of R4's podiatry service. - Review of R5's medical record revealed she moved into the facility on 01/19/24 with a diagnosis of dementia. R5's "Functional Capacity Screen" dated 03/10/26 identified R5 needed physical assistance with activities of daily living and could not manage her medications or medical treatments. R5's "Negotiated Service Agreement", titled "Negotiated Service/Health Care Plan" (NSA/HCP) dated 03/10/26 identified she received podiatry services but did not identify the provider of the service, Interview on 04/27/26 at 02:55 PM Operator/Nurse reported she did not realize she needed to include in the NSA/HCP "who" provided the service. The operator failed to ensure designated staff completed R5's NSA/HCP to include the provider	S5105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087231	A. BUILDING: _____ B. WING _____	04/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMANI HOME PLUS	1201 N PINECREST ST WICHITA, KS 67208

(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 3 of R5's podiatry service.	S5105		
S5116 SS=E	26-42-202 (d) NSA revisions (d) Each administrator or operator shall ensure the review and, if necessary, revision of each negotiated service agreement according to the following requirements: (1) At least once every 365 days;(2) following any significant change in condition, as defined in K.A.R. 26-39-100; (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant; and (4) if requested by the resident or the resident ' s legal representative, staff, the case manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. This REQUIREMENT is not met as evidenced by: KAR 26-42-202(d)(2) The facility reported a census of eight residents(R). The sample included three residents. Based on interview, and record review the operator failed to ensure designated staff reviewed and revised two (R3 and R4) of three sampled residents "Negotiated Service Agreement" within 365 days for R3, and following a significant change in condition as defined in KAR 26-39-100 for R4. Findings Included: - Review of R3's medical record revealed she	S5116		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087231	A. BUILDING: _____ B. WING _____	04/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMANI HOME PLUS	1201 N PINECREST ST WICHITA, KS 67208

(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
S5116	Continued From page 4	S5116		

moved into the facility on 10/06/23 with a diagnosis of dementia.

R3's "Functional Capacity Screen" dated 01/09/26 revealed she needed physical assistance with all activities of daily living and could not manage her medications or medical treatments.

R3's current "Negotiated Service Agreement", titled "Negotiated Service/Health Care Plan" (NSA/HCP) dated 01/09/26 was completed 91 days after her previous NSA/HCP dated 10/10/24.

Interview on 04/27/26 at 02:59 PM Operator/Nurse A reviewed R3's record and confirmed the NSA/HCP was completed late.

The operator failed to ensure designated staff reviewed and revised, if necessary, R3's NSA/HCP at least once every 365 days.

- Review of R4's medical record revealed he moved into the facility on 04/25/25 with a diagnosis of diabetes mellitus type II.

R4's "Functional Capacity Screen" dated 04/25/25 identified he needed physical assistance with activities of daily living and could not manage his medications and medical treatments.

R4's "Negotiated Service Agreement", titled "Negotiated Service/Health Care Plan" (NSA/HCP) dated 04/25/25 identified he received Home Health services from a local company for Nursing administration of his insulin.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087231	A. BUILDING: _____ B. WING _____	04/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMANI HOME PLUS	1201 N PINECREST ST WICHITA, KS 67208

(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
S5116	Continued From page 5 R4's record included an order dated 06/03/25 to discharge from Home Health and Start Hospice Services. R4's record lacked revisions to identify he no longer received Home Health Services and was on Hospice Services. Interview on 04/27/26 at 03:02 PM Operator/Nurse A confirmed he had been discharged from Home Health and Started on Hospice. She confirmed she failed to complete a revision to R4's NSA/HCP to identify the changes in services. The operator failed to ensure designated staff reviewed/revised R4's NSA/HCP when he had a significant change in condition as defined in KAR 26-39-100.	S5116		
S5215 SS=F	26-42-104 (d) Disaster and Emergency Preparedness Education (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the home ' s emergency management plan; (2) education of each resident upon admission to the home regarding emergency procedures; (3) quarterly review of the home ' s emergency management plan with employees and residents; and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location.	S5215		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087231	A. BUILDING: _____ B. WING _____	04/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMANI HOME PLUS	1201 N PINECREST ST WICHITA, KS 67208

(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
S5215	Continued From page 6 This REQUIREMENT is not met as evidenced by: KAR 26-42-104 (d)(3) The facility reported a census of eight residents. Based on record review and interviews, the operator failed to ensure disaster and emergency preparedness by the failure to ensure designated staff conducted quarterly reviews of the home's emergency management plan with all residents and staff. Findings included: - Review of "Fire" information notebook provided by Operator/Nurse A on 04/27/26 included documentation reviewing the emergency management with the following information: 06/17/25 - included five staff and nine residents 01/05/26 - included seven staff 01/17 26 - included four staff and ten residents 02/24/26 - included nine residents On 04/27/26 at 10:17 AM Operator/Nurse A looked through the "Fire" book and confirmed reviews of the third and fourth quarter for 2025 were not in the fire book. Operator/Nurse A was sure she had conducted reviews and continued to look in other notebooks. As of 03:55 PM on 04/27/26 when surveyor left the facility, Operator/Nurse A had not been able to find evidence of reviewing the emergency management plan during the third and fourth	S5215		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087231	A. BUILDING: _____ B. WING _____	04/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMANI HOME PLUS	1201 N PINECREST ST WICHITA, KS 67208

(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
S5215	Continued From page 7 quarter of 2025. As of 04/28/26 at 08:24 AM Operator/Nurse A had not provided evidence of reviewing the emergency management plan during the third and fourth quarter of 2025. The operator failed to ensure disaster and emergency preparedness by the failure to conduct quarterly reviews of the emergency management plan with all residents and staff.	S5215		
S9999	Final Observations K.S.A.39-928 Upon receipt of an application for license, the licensing agency with the approval of the state fire marshal shall issue a license if the applicant is fit and qualified and if the adult care home facilities meet the requirements established under this law. A license, unless sooner suspended or revoked, shall remain in effect upon filing by the licensee, and approval by the licensing agency and the state fire marshal or their duly authorized agents, of an annual report upon such uniform dates and containing information in such form as the licensing agency prescribes and payment of an annual fee. S/S level F This requirement is not met as evidenced by: Findings included: Department records revealed the facility failed to	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087231	A. BUILDING: _____ B. WING _____	04/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMANI HOME PLUS	1201 N PINECREST ST WICHITA, KS 67208

(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
S9999	Continued From page 8 file and pay the annual renewal licensing fees for 2022, 2023, 2024, 2025 and 2026. Interview on 04/27/26 at 03:41 PM Operator/Nurse A reported she was sure she had completed payments for renewing the Home Plus license with the state. Operator/Nurse A reported she was going to look through her emails and receipts to find payment information. Surveyor also gave Operator/Nurses A contact information for the appropriate department related to renewal of licenses. As of 04/28/26 at 08:45 AM Operator/Nurse A had not provided information to show she had completed the appropriate payments for renewal of the Home Plus license. The facility failed to file and pay the 2022, 2023, 2024,2025 and 2026 annual renewal licensing fee to the department as required by KSA 39-928.	S9999		