STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087069	A. BUILDING: _____ B. WING _____	07/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENT PARK ASSISTED LIVING AND MEMORY CAF	10600 E 13TH STREET NORTH WICHITA, KS 67206

(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 172725, 172425, 171292, 170431, 169499, 167462, 168337, 168479, 168374, and 167849, for the above named facility conducted on 07/25/33 , 07/26/22, 07/27/22 and 07/28/22.	S 000		
S3310 SS=F	26-41-207 (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; and (c) Each administrator or operator shall ensure the facility ' 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: KAR 26-41-207 (c) The facility reported a census of 65 residents. The sample included six residents, three closed record reviews and five newly hired employees (Licensed Nurses (LN) A and B, Certified Medication Aide (CMA) C, and Certified Nurse Aide (CNA) D. Based on record review and interview the administrator failed to ensure the facility's compliance with the department's	S3310		

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
	N087069	A. BUILDING: _____ B. WING _____	07/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENT PARK ASSISTED LIVING AND MEMORY CAR	10600 E 13TH STREET NORTH WICHITA, KS 67206

(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
S3310	Continued From page 1 "tuberculosis" (TB) guidelines for adult care homes adopted by reference in KAR 26-39-105 for four of the 5 newly hired employees (LN A and B, CMA C and CNA D). Findings Included: - On 07/26/22 record review of the personnel file of newly hired LN A, revealed a hire date of 04/28/22. The record contained a TB screening from dated 04/28/22. The personnel record lacked documentation of the required two step TB test within seven days of employment. On 07/26/2022 record review of the personnel file of newly hired LN B, revealed a hire date of 07/13/22. The record contained a TB screening form dated 07/13/22. The personnel record lacked documentation of the required two step TB test within seven days of employment. On 07/26/22 record review of the personnel file of newly hired CMA C, revealed a hire date of 06/01/22. The record contained a TB screening from dated 06/01/22. The personnel record lacked documentation of the required two step TB test within seven days of employment. On 07/26/22 record review of the personnel file of newly hired CNA D, revealed a hire date of 05/10/22. The record contained a TB screening form dated 05/10/22. The personnel record lacked documentation of the required two step TB test within seven days of employment. Interview on 7/28/2022 with LN A and administrator E confirmed the newly hired personnel records lacked the required two step TB test for four of the five newly hired employees.	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087069	A. BUILDING: _____ B. WING _____	07/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENT PARK ASSISTED LIVING AND MEMORY CAF	10600 E 13TH STREET NORTH WICHITA, KS 67206

(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
S3310	Continued From page 2 The administrator failed to ensure the facility's compliance with the department's "tuberculosis" (TB) guidelines for adult care homes adopted by reference in KAR 26-39-105 for four of the 5 newly hired employees (LN A and B, CMA C and CNA D), with the potential to effect all residents.	S3310		