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 _____	06/21/2022

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 resurvey at the above named home plus facility conducted on 06/20/22 and 06/21/22.	S 000		
S5230 SS=E	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: K.A.R 26-42-207 (c) The census totaled 7 residents. The sample included 3 residents and review of 5 newly hired employees. Based on record review and interview for 2 Residents (R)620 and R832 and 4 staff (Certified Medication Aide (CMA) B, CMA C, CMA D and Certified Nurse Aide (CNA) E), the facility failed to ensure compliance with the State Agency's tuberculosis (TB) guidelines. Findings included: - Review of R620's health record revealed he	S5230		

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

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S5230	Continued From page 1 admitted to the facility on 04/01/22 and the record lacked evidence of a TB questionnaire upon admission. Review of R832's health record revealed he admitted to the facility on 04/15/22 and the record lacked evidence of a TB questionnaire upon admission. Review of CMA B's employee record revealed they hired onto the facility on 01/11/21. CMA B's record lacked evidence of a TB questionnaire upon hire. Review of CMA C's employee record revealed they hired onto the facility on 07/05/20. CMA C's record lacked evidence of a TB questionnaire upon hire. Review of CMA D's employee record revealed they hired onto the facility on 04/28/21. CMA D's record lacked evidence of a TB questionnaire upon hire. Review of CNA E's employee record revealed they hired onto the facility on 04/14/20. CNA E's record lacked evidence of a TB questionnaire upon hire. Interview on 06/20/22 at 12:45 PM with Operator/ Licensed Nurse A confirmed TB questionnaires were not completed upon admission for R620 and R832. Electronic interview on 06/21/22 at 11:54 AM with Operator/ Licensed Nurse A confirmed no TB questionnaire completed upon hire for CMA B. Electronic interview on 06/21/22 at 1:53 PM with Operator/ Licensed Nurse A confirmed no TB	S5230		

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S5230	Continued From page 2 questionnaire completed upon hire for CMA C, CMA D and CNA E. The facility's "Tuberculosis Policy and Procedure" (no date) recorded, "Each resident/employee shall have an annual TB symptom screen that includes completion of the symptom review questionnaire." The facility failed to ensure compliance with the State Agency's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105, which had the potential to affect all residents.	S5230		