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 _____	R 07/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENT PARK ASSISTED LIVING AND MEMORY CAF	10600 E 13TH ST 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 citation represents the findings of a revisit for notice of assessment 16-33 of the above assisted living facility on 7/26/16 and 7/27/16.	{S 000}		
S3028 SS=E	26-41-101 (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 facility 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. This REQUIREMENT is not met as evidenced by:	S3028		

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

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REGENT PARK ASSISTED LIVING AND MEMORY CAR	10600 E 13TH ST NORTH WICHITA, KS 67206

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S3028	Continued From page 1 KAR 26-41-103(f)(3)(A)(B) The facility reported a census of 82 residents. The sample included 6 residents. Based on record review and interview for 2 (#1000 and #1200) of 6 residents sampled, the administrator failed to report an allegation of resident abuse to the department within 24 hours and failed to thoroughly investigate and take measures to prevent further potential abuse while the investigation was in progress. Findings included: - Record review for resident #1000 revealed an admission date of 1/6/14 and diagnoses of hypertension and syncope. The functional capacity screen dated 5/6/16 indicated the resident required physical assistance with bathing, dressing, toileting, transferring, and mobility; was at risk for falls; utilized a wheelchair for mobility; and experienced impaired short-term memory and decision making. The functional capacity screen indicated the resident's long-term memory and memory recall were intact. The negotiated service agreement/health care service plan dated 5/6/16 documented the services provided by facility staff as physical assistance with bathing, toileting, and transferring. Staff members to assist with dressing as needed and resident independent with mobility after staff transfer resident to wheelchair. The resident notes contained an entry by licensed nurse B at 1:05 p.m. on 6/19/16: "CNA (certified nursing assistant) reported to this nurse that res	S3028		

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S3028	Continued From page 2	S3028		

(resident) stated (he/she) had been hurt by staff and has bandages to one of (his/her) knees. This nurse went to assess and take res statement. Res. states last night a (person) wouldn't help (him/her) to the bathroom and told (him/her) (he/she) needed to move (resident) wheelchair on own. (He/she) stated they got into an argument and helper swung something and it hit (resident), then (resident) says helper pushed (resident) into wall while in wheelchair. Bruising noted to (bilateral) medial (middle of) knees. Skin tear measuring 0.5 x 1.1 cm (centimeters) to L (left) knee." Licensed nurse B documented notification of resident ' s durable power of attorney, health care coordinator, and resident director and statements obtained from staff related to incident.

Interview with resident #1000 at 3:45 p.m. on 7/26/16 in the resident's room. When resident was asked about treatment by staff when receiving care, resident stated some staff rush (him/her) when transferring to wheelchair. Resident denied reporting this to nurse and stated he/she did not want to get anyone in trouble. Resident confirmed he/she had bruises to both knees last month and said could have been caused when transferred to wheelchair.

At 4:00 p.m. on 7/26/16, licensed nurse A stated incident (as reported by resident to licensed nurse B) was investigated and left to look for the investigation.

At 4:15 p.m. on 7/26/16, licensed nurse A stated the allegation was not reported to the department.

At 4:20 p.m. on 7/26/16, administrator C stated a written investigation was not conducted because resident changed (his/her) story. Licensed nurse A confirmed he/she did not investigate the cause

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S3028	Continued From page 3 of the bruises to knees. The administrator failed to report an allegation of resident abuse involving resident #1000 to the department within 24 hours and failed to thoroughly investigate and take measures to prevent further potential abuse while the investigation was in progress. - Record review for resident #1200 revealed an admission date of 10/17/14 and diagnosis of metastatic breast cancer. The functional capacity screen dated 5/12/16 indicated the resident required physical assistance with bathing, dressing, and toileting; supervision with transferring and mobility, was at risk for falls; utilized a walker; and experienced impaired short-term and long-term memory, decision making, and memory recall. The negotiated service agreement/health care service plan dated 5/12/16 documented all activities of daily living provided by a private duty caregiver with facility staff providing care as needed. The resident notes contained the following entries: 6/22/16 at 4:00 a.m. licensed nurse B documented private duty caregiver reported a skin tear measuring 1.5 centimeters in diameter to resident's left lower leg that must have happened yesterday. Cause of skin tear unknown. 6/24/16 at 3:20 a.m. licensed nurse B documented skin tear measuring 3 centimeters by 2.75 centimeters on left lower leg below the	S3028		

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S3028	Continued From page 4 skin tear noted on 6/22/16. At 3:00 p.m. on 7/26/16, licensed nurse A stated presence of skin tears were reported to hospice nurse and staff were asked about possible cause of skin tear but cause of injuries undetermined. Licensed nurse A stated the cause of the injuries were not reported to the department or investigated. The administrator failed to report an allegation of resident abuse and or neglect involving resident #1200 to the department within 24 hours and failed to thoroughly investigate and take measures to prevent further potential abuse while the investigation was in progress.	S3028		