STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N097003	A. BUILDING: _____ B. WING _____	R-C 11/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRVIEW ESTATES RETIREMENT COMMUNITY, INC	1630 SEWELL AVENUE COLBY, KS 67701

(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 revisit for correction order 20-47 conducted on 11/2/2020, 11/03/2020, 11/04/2020, 11/05/2020, 11/09/2020, 11/10/2020, 11/12/2020, 11/16/2020 and 11/17/2020.	{S 000}		
{S3085} SS=E	26-41-202 (a) Negotiated Service Agreement (a) The administrator or operator of each assisted living facility or residential health care facility 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 26-41-202 (a) (1) (2) (3) The facility reported a census of 25 residents. The sample included 6 focused review residents and 1 closed record review. Based on record review and interview for 2 (#1626, #1848) of 6 focused record review residents, the operator	{S3085}		

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
	N097003	A. BUILDING: _____ B. WING _____	R-C 11/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRVIEW ESTATES RETIREMENT COMMUNITY, INC	1630 SEWELL AVENUE COLBY, KS 67701

(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
{S3085}	Continued From page 1	{S3085}		

failed to ensure the Negotiated Service Agreement (NSA) completed for residents who required health care services, was done in collaboration with the resident or the resident's legal representative and contained a description of the services the resident received, identified the provider of each service and identified each party responsible for payment if outside resources provided a service.

Findings included:

- Record review for resident #1626 revealed admission date of 03/09/18 with diagnoses of depression, anxiety, hypothyroidism, diabetes mellitus type I, hypokalemia, hypertension, edema, and congestive heart failure.

Review of resident's functional capacity screen (FCS) dated 03/05/2020 recorded the resident could not manage her medications and treatments.

Review of resident's negotiated service agreement (NSA) dated 03/05/2020 recorded the facility staff would manage the resident's medications.

Review of resident's Health Care Service Plan (HCSP) dated 03/05/2020 recorded the facility staff would administer medications and treatments.

NSA lacked a description of services for diabetic management including who performed blood glucose monitoring and administration of insulin.

- Record review for resident #1848 revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N097003	A. BUILDING: _____ B. WING _____	R-C 11/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRVIEW ESTATES RETIREMENT COMMUNITY, INC	1630 SEWELL AVENUE COLBY, KS 67701

(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
{S3085}	Continued From page 2	{S3085}		

admission date of 05/23/18 with diagnoses of hypertension, anxiety, depression, angina, and hyperlipidemia.

Review of resident's functional capacity screen (FCS) dated 09/18/19 revealed the resident required supervision with bathing, dressing, toileting, transfer, walk/mobility, eating, and could not manage her medications and treatments.

Review of resident's negotiated service agreement (NSA) dated 9/18/19 recorded the facility staff to provide assistance with bathing, toileting, and walk/mobility and would assist with management of the resident's medications and treatments.

Physician's written order (no date) recorded order for physical therapy (PT).

Physician's written order dated 08/14/2020 recorded resident to continue working with physical therapy (PT) regarding dizziness and gait stability.

NSA lacked signature of resident/responsible party, description of services provided by physical therapy, and identification of provided the therapy.

Interview on 11/02/2020 at 3:39 PM with operator stated resident no longer receiving PT services and confirmed NSA had not been updated.

Interview on 11/12/2020 at 12:22 PM with operator confirmed resident #1848 ended PT on 10/15/2020.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N097003	A. BUILDING: _____ B. WING _____	R-C 11/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRVIEW ESTATES RETIREMENT COMMUNITY, INC	1630 SEWELL AVENUE COLBY, KS 67701

(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
{S3085}	Continued From page 3 The operator failed to ensure the Negotiated Service Agreement (NSA) was done in collaboration with the resident or the resident's legal representative and contained a description of the services the residents would receive, identified the provider of each service and identified each party responsible for payment if outside resources provided a service.	{S3085}		
{S3166} SS=F	26-41-204 (e) Delegation of Duties (e) A licensed nurse may delegate nursing procedures not included in the nurse aide or medication aide curriculums to nurse aides or medication aides, respectively, under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto. This REQUIREMENT is not met as evidenced by: KAR 26-41-204 (e) The facility reported a census of 25 residents. The sample 6 focused record review residents and 1 closed record review resident. Based on record review and interview for 1 (#1626) of 6 sampled residents and 2 non-sampled residents (#1910, #1930) requiring "accuchecks" (blood sugar monitoring with a glucometer), a nursing procedure not included in the medication aide curriculum, the operator failed to ensure the licensed nurse delegated the procedure to medication aides under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto.	{S3166}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N097003	A. BUILDING: _____ B. WING _____	R-C 11/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRVIEW ESTATES RETIREMENT COMMUNITY, INC	1630 SEWELL AVENUE COLBY, KS 67701

(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
{S3166}	Continued From page 4 Findings included: - On 11/02/2020 at 1:58 PM, personnel hired since date of last survey document obtained, no new CMAs hired since date of last survey. Requested accucheck delegation for all currently employed CMAs (Certified Medication Aide) from operator. On 11/02/2020 at 2:15 PM, operator confirmed she had no delegation records for CMAs, nor a policy. Interview on 11/02/2020 at 2:45 PM with certified staff #D stated she had not had an assessment done on glucometers by a licensed nurse. Interview on 11/02/2020 at 2:53 PM with certified staff #C stated she had not had an assessment done on glucometers by a licensed nurse. For residents requiring "accuchecks", a nursing procedure not included in the medication aide curriculum, the administrator failed to ensure the licensed nurse delegated the procedure to medication aides under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto.	{S3166}		
{S3175} SS=F	26-41-205 (a) (1) Self Administration of Medication (a) Self-administration of medication. Any resident may self-administer and manage medications independently or by using a medication container or syringe prefilled by a licensed nurse or pharmacist or by a family member or friend providing this service	{S3175}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N097003	A. BUILDING: _____ B. WING _____	R-C 11/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRVIEW ESTATES RETIREMENT COMMUNITY, INC	1630 SEWELL AVENUE COLBY, KS 67701

(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
{S3175}	Continued From page 5 gratuitously, if a licensed nurse has performed an assessment and determined that the resident can perform this function safely and accurately without staff assistance. (1) An assessment shall be completed before the resident initially begins self-administration of medication, if the resident experiences a significant change of condition, and annually. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (a) (1) The facility reported a census of 25 residents. The sample included 6 focus review residents and 1 closed record review resident. Based on record review and interview for 2 (#1940, #1960) of 6 focused record review residents, the operator failed to ensure a licensed nurse performs an assessment annually for residents who self-administer medications. Findings included: - Record review for resident #1940 recorded admission date of 01/21/19 with diagnoses of hypertension and hypothyroidism. Functional Capacity Screen dated 09/29/19 recorded resident independent with management of medications and treatments. Health Care Service Plan (HCSP) dated	{S3175}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N097003	A. BUILDING: _____ B. WING _____	R-C 11/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRVIEW ESTATES RETIREMENT COMMUNITY, INC	1630 SEWELL AVENUE COLBY, KS 67701

(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
{S3175}	Continued From page 6 09/29/19 recorded resident independent with management of medications and treatments. Negotiated Service Agreement (NSA) dated 09/29/19 recorded resident independent with management of medications and treatments. Self-administration of medications evaluation dated 01/30/19. Signed physician's order dated 01/30/19 recorded resident to continue self- administration of medications. Resident roster identified resident #1940 as self-administering medications. Record lacked an annual assessment for 2020. - Record review for resident #1960 recorded admission date of 01/01/19 with diagnoses of hypertension, osteoarthritis and edema. Functional Capacity Screen dated 09/29/19 recorded resident independent with management of medications and treatments. Health Care Service Plan (HCSP) dated 09/29/19 recorded resident independent with management of medications and treatments. Negotiated Service Agreement (NSA) dated 09/28/19 recorded resident independent with management of medications and treatments. Self-administration of medications evaluation dated 03/05/19. Signed physician's order dated 03/01/19	{S3175}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N097003	A. BUILDING: _____ B. WING _____	R-C 11/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRVIEW ESTATES RETIREMENT COMMUNITY, INC	1630 SEWELL AVENUE COLBY, KS 67701

(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
{S3175}	Continued From page 7 recorded resident to continue self- administration of medications. Resident roster identified resident #1960 as self-administering medications. Record lacked an annual assessment for 2020. Interview on 11/02/2020 at 4:13 PM with operator states, "Then they must not have been done" when updated self-administration of medication assessments were requested. Facility medication administration policy recorded, "The community RN shall complete the assessment before the resident initially begins self-administration of medication, if the resident experiences a significant change, and annually." The operator failed to ensure a licensed nurse performs an assessment annually for residents who self-administer medications.	{S3175}		
{S3202} SS=F	26-41-205 (d) (4) Delegation of Medication Administration (4) Any licensed nurse may delegate nursing procedures not included in the medication aide curriculum to medication aides under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(d)(4) The facility reported a census of 25 residents. The sample included 6 focus review residents	{S3202}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N097003	A. BUILDING: _____ B. WING _____	R-C 11/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRVIEW ESTATES RETIREMENT COMMUNITY, INC	1630 SEWELL AVENUE COLBY, KS 67701

(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
{S3202}	Continued From page 8 and 1 closed record review. Based on record review and interview for 1 (#1626) of 6 sampled resident and 2 (#1910, #1930) non-sampled residents, the operator failed to ensure the licensed nurse delegated nursing procedures not included in the medication aide curriculum to medication aides under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto when medication aides dialed insulin pens for the residents without an assessment for competency by a licensed nurse. Findings included: - Record review for resident #1626 revealed admission date of 03/09/18 with diagnoses of depression, anxiety, hypothyroidism, diabetes mellitus type I, hypokalemia, hypertension, edema, and congestive heart failure. Review of resident's functional capacity screen (FCS) dated 03/05/2020 recorded the resident could not manage her medications and treatments. Review of resident's negotiated service agreement (NSA) dated 03/05/2020 recorded the facility staff would manage the resident's medications. Review of resident's Health Care Service Plan (HCSP) dated 03/05/2020 recorded the facility staff would administer medications and treatments. Resident roster identified 3 residents that received insulin by injection.	{S3202}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N097003	A. BUILDING: _____ B. WING _____	R-C 11/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRVIEW ESTATES RETIREMENT COMMUNITY, INC	1630 SEWELL AVENUE COLBY, KS 67701

(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
{S3202}	Continued From page 9 Interview on 11/02/2020 at 2:15 PM with operator confirmed she does not have competency checkoffs with certified medication aide staff. Interview on 11/02/2020 at 2:45 PM with certified staff #D stated she had not had an assessment done on insulin pens by a licensed nurse. Interview on 11/02/2020 at 2:53 PM with certified staff #C stated she had not had an assessment done on insulin pens by a licensed nurse. The operator failed to ensure the licensed nurse delegated nursing procedures not included in the medication aide curriculum to medication aides under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto when medication aides dialed insulin pens for the residents without an assessment for competency by a licensed nurse.	{S3202}		
{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	{S3310}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N097003	A. BUILDING: _____ B. WING _____	R-C 11/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRVIEW ESTATES RETIREMENT COMMUNITY, INC	1630 SEWELL AVENUE COLBY, KS 67701

(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 10 This REQUIREMENT is not met as evidenced by: K.A.R 26-41-207 (c) The facility reported a census of 25 residents. The sample included 4 newly hired employee records. Based on record review and interview for 4 of 4 sampled staff, the operator failed to ensure compliance with the department's tuberculosis guidelines. Findings included: - Review of 4 newly hired employees revealed the following: Certified staff #G hired onto the facility on 10/15/2020. Staff C's record lacked evidence of TB (tuberculosis) testing upon hire. Record lacked evidence of completion of a TB questionnaire upon hire. Certified staff #H hired onto the facility on 10/16/2020. Staff H's record lacked evidence of TB testing upon hire. Record lacked evidence of completion of a TB questionnaire upon hire. Certified staff #I hired onto the facility on 10/20/2020. Staff I's record lacked evidence of TB testing upon hire. Record lacked evidence of completion of a TB questionnaire upon hire. Certified staff #J hired onto the facility on 10/15/2020. Staff J's record lacked evidence of TB testing upon hire. Record lacked evidence of completion of a TB questionnaire upon hire.	{S3310}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N097003	A. BUILDING: _____ B. WING _____	R-C 11/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRVIEW ESTATES RETIREMENT COMMUNITY, INC	1630 SEWELL AVENUE COLBY, KS 67701

(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 11 During an interview on 11/02/2020 at 2:15 PM, operator confirmed she did not have TB skin tests and symptom screens on the 4 newly hired sampled employees. Operator confirmed she did not have TB skin tests and yearly symptom screens done on all other employed staff. Facility tuberculosis testing policy recorded, "Each new resident and new employee shall have an initial TB symptom screen that includes the components of the Tuberculosis Symptom Screen Questionnaire within 7 days of residency or employment or at the time of administration of the tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA)." Policy further stated, "Each new resident or new employee shall receive a two-steo TST or IGRA for Mycobacterium tuberculosis within 7 days of residency or employment." Policy also stated, "Each resident and employee shall have an annual TB symptom screen that includes the components of the Tuberculosis Symptom Screen Review Questionnaire." The operator failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105.	{S3310}		