STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N034001	A. BUILDING: _____ B. WING _____	08/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN PRAIRIE SENIOR LIVING LLC	510 E SAN JACINTO AVENUE ULYSSES, KS 67880

(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 assisted living facility conducted on 8/12,13,14/2019.	S 000		
S 110 SS=E	26-39-103 (c) NOTICE OF RIGHTS AND SERVICES (c) Notice of rights and services. (1) Before admission, the administrator or operator shall ensure that each resident or the resident's legal representative is informed, both orally and in writing, of the following in a language the resident or the resident ' s legal representative understands: (A) The rights of the resident; (B) the rules governing resident conduct and responsibility; (C) the current rate for the level of care and services to be provided; and (D) if applicable, any additional fees that will be charged for optional services. (2) The administrator or operator shall ensure that each resident or the resident ' s legal representative is notified in writing of any changes in charges or services that occur after admission and at least 30 days before the effective date of the change. The changes shall not take place until notice is given, unless the change is due to a change in level of care. This STANDARD is not met as evidenced by: KAR 26-39-103 The facility reported a census of 14 residents. The sample included 3 residents and 1 focused review. Based on interview and record review the administrator failed to ensure before admission, 2 (#812 and#832) of 4 residents/legal	S 110		

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

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S 110	Continued From page 1 representative were informed by staff both orally and in writing, of the rights of the resident and the rules governing resident conduct and responsibility. Findings included: - Review of resident #812's record revealed he/she admitted to the home on 5-4-18 with diagnosis of reflux disease, diabetes mellitus type 2 and primary osteoarthritis. - Review of resident #832's record revealed the resident admitted to the facility on 9-19-15 with diagnosis of nausea, constipation, dermatitis, reflux disease, heart failure, anxiety, and right arm pain. Review of the resident #812 and #832's medical record lacked evidence of being informed of the rights as a resident and rules governing their conduct and responsibility. During an interview on 8-13-19 administrative staff B reported he/she could not find evidence of providing information related to resident rights and rules of the facility. The administrator failed to ensure before admission residents were informed by staff both orally and in writing, of their rights and the rules governing resident conduct and responsibility.	S 110		
S 230 SS=E	26-39-102 (b) (c) Admission Advanced Directives Resident Rights b) At the time of admission, adult care home staff shall inform the resident or the resident ' s legal representative, in writing, of the state statutes	S 230		

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S 230	Continued From page 2 related to advance medical directives. (1) If a resident has an advance medical directive currently in effect, the facility shall keep a copy on file in the resident ' s clinical record. (2) The administrator or operator, or the designee, shall ensure the development and implementation of policies and procedures related to advance medical directives. (c) The administrator or operator, or the designee, shall provide a copy of resident rights, the adult care home's policies and procedures for advance medical directives, and the adult care home's grievance policy to each resident or the resident's legal representative before the prospective resident signs any admission agreement. This REQUIREMENT is not met as evidenced by: KAR 26-39-102(b) The facility reported a census of 14 residents. The sample included 3 residents and 1 focused review. Based on interview and record review the administrator failed to ensure at the time of admission, 2 (#812 and#832) of 4 residents/legal representative were informed by staff of the state statutes related to advance medical directives. Findings included: - Review of resident #812's record revealed he/she admitted to the home on 5-4-18 with diagnosis of reflux disease, diabetes mellitus type 2 and primary osteoarthritis. - Review of resident #832's record revealed the resident admitted to the facility on 9-19-15 with	S 230		

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S 230	Continued From page 3 diagnosis of nausea, constipation, dermatitis, reflux disease, heart failure, anxiety, and right arm pain. Review of both resident records lacked evidence of the resident/legal representative being informed of state statutes related to advanced medical directives. During an interview on 8-13-19 administrative staff B reported he/she could not find evidence of providing information related to advanced directives to the resident or the resident's family. The administrator failed to ensure at the time of admission the residents/legal representatives were informed of the state statutes related to advanced medical directives.	S 230		
S3101 SS=E	26-41-202 (h) NSA Signatures (h) Each individual involved in the development of the negotiated service agreement shall sign the agreement. The administrator or operator shall ensure that a copy of the initial agreement and any subsequent revisions are provided to the resident or the resident's legal representative. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(h) The facility reported a census of 14 residents. The sample included 3 residents and 1 focused record review. Based on record review and interview the administrator failed to ensure designated staff had each individual involved in	S3101		

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S3101	Continued From page 4	S3101		

the development of the negotiated service agreement sign the agreement for 3 (#812, #822, #832) of 4 residents.

Findings included:

- Review of resident #812's record revealed he/she admitted to the home on 5-4-18 with diagnosis of reflux disease, diabetes mellitus type 2 and primary osteoarthritis.

Review of the resident's functional capacity screen dated 5-21-19 revealed the resident was independent with activities of daily living, had bladder incontinence, and impaired hearing.

Review of the resident's negotiated service agreement dated 5-21-19 revealed the resident was independent with all activities of daily living and wore hearing aides. The negotiated service agreement lacked signatures of the nurse who completed the service agreement.

- Review of resident #822's record revealed he/she admitted to the facility on 5-31-19 with diagnosis of hypertension and cerebral ischemic attack.

Review of the resident's functional capacity screen dated 5-20-19 revealed the resident required physical assistance with dressing and management of medications and treatments, had bladder incontinence, impaired cognition and communication and impaired vision and hearing.

Review of the negotiated service agreement dated 5-31-19 revealed the resident's spouse assisted with am and PM cares and also gave the resident his/her medications. The negotiated service agreement lacked the signature of the

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S3101	Continued From page 5 nurse who completed the service agreement. - Review of resident #832's record revealed the resident admitted to the facility on 9-19-15 with diagnosis of nausea, constipation, dermatitis, reflux disease, heart failure, anxiety, and right arm pain. Review of the resident's functional capacity screen dated 5-25-19 revealed the resident needed physical assistance with bathing and dressing and supervision with toileting. The resident was frequently incontinent of bladder and had impaired cognition and vision. Review of the negotiated service agreement dated 5-25-19 revealed 1 staff person assisted the resident with bathing 3 times per week and assisted the resident with dressing. The resident wore incontinent briefs and staff supervised the resident with toileting. The negotiated service agreement lacked the signatures of the nurse and the resident who developed the service agreement. Interview on 8-13-19 at 3:00 PM administrative staff B confirmed the above service agreements did not contain the signatures of all those who participated in the development oaf the negotiated service agreement. The administrator failed to ensure the negotiated service agreements contained the signatures of all those who participated in the development of the negotiated service agreement.	S3101		
S3165 SS=E	26-41-204 (d) Health Care Services (d) The negotiated service agreement shall	S3165		

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S3165	Continued From page 6 contain a description of the health care services to be provided and the name of the licensed nurse responsible for the implementation and supervision of the plan. This REQUIREMENT is not met as evidenced by: KAR-26-41-204(d) The facility reported a census of 14 residents. The sample included 3 residents and 1 focused review. Based on record review and interview, the Administrator failed to ensure the negotiated service agreement contained the name of the licensed nurse responsible for the implementation and supervision of the health service plan for 3 (#812,#822, #832) of 4 sampled residents. Findings included: - Review of resident #812's record revealed he/she admitted to the home on 5-4-18 with diagnosis of reflux disease, diabetes mellitus type 2 and primary osteoarthritis. Review of the resident's functional capacity screen dated 5-21-19 revealed the resident was independent with activities of daily living, had bladder incontinence, and impaired hearing. Review of the resident's negotiated service agreement dated 5-21-19 revealed the resident was independent with all activities of daily living and wore hearing aides. The negotiated service agreement lacked the name of the nurse responsible for the implementation of the health service plan.	S3165		

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S3165	Continued From page 7	S3165		

- Review of resident #822's record revealed he/she admitted to the facility on 5-31-19 with diagnosis of hypertension and cerebral ischemic attack.

Review of the resident's functional capacity screen dated 5-20-19 revealed the resident required physical assistance with dressing and management of medications and treatments, had bladder incontinence, impaired cognition and communication and impaired vision and hearing. .

Review of the negotiated service agreement dated 5-31-19 revealed the resident's spouse assisted with am and PM cares and also gave the resident his/her medications. The negotiated service agreement lacked the name of the nurse responsible for implementation of the health service plan.

- Review of resident #832's record revealed the resident admitted to the facility on 9-19-15 with diagnosis of nausea, constipation, dermatitis, reflux disease, heart failure, anxiety, and right arm pain.

Review of the resident's functional capacity screen dated 5-25-19 revealed the resident needed physical assistance with bathing and dressing and supervision with toileting. The resident was frequently incontinent of bladder and had impaired cognition and vision.

Review of the negotiated service agreement dated 5-25-19 revealed 1 staff person assisted the resident with bathing 3 times per week and assisted the resident with dressing. The resident wore incontinent briefs and staff supervised the resident with toileting. The negotiated service agreement lacked the name of the nurse

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S3165	Continued From page 8 responsible for the implementation of the health service plan. During an interview on 8-13-19 at 1:40 PM administrative staff B confirmed the above negotiated service agreements lacked the name of the nurse responsible for the implementation of the health service plan. The administrator failed to ensure designated staff included the name of the nurse responsible for the implementation of the health service plan in the negotiated service agreement.	S3165		
S3171 SS=E	26-41-204 (i) Health Care Services Standards of Practice (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(i) The facility reported a census of 14 residents. The sample included 3 residents and 1 focused record review. Based on interview, and record review the administrator failed to ensure all health care services were provided to residents by qualified staff for 2 (#812 and #822) of 3 residents in accordance with acceptable standards of practice related to the performance of neurological assessment after the resident's had a fall and hit their head. Findings included:	S3171		

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S3171	Continued From page 9 - Review of resident #812's medical record revealed he admitted to the facility on 5-4-18 with diagnoses of reflux disease, primary osteoarthritis, and diabetes mellitus. Review of the resident's functional capacity screen dated 5-21-19 revealed the resident was independent with all activities of daily living and was not a fall risk. Review of the resident's negotiated service agreement the resident administered his own medications. Review of the residents record revealed the resident had a witnessed fall where he hit his head. The record include a "neurological flow sheet" which assessed the residents level of consciousness, extremity movements, hand grasp, pupil size and reaction to light, speech, and vital signs. It also included initials of the person who completed the assessment. - Review of resident #822's medical record revealed he admitted to the facility on 5-31-19 with diagnoses of hypertension and cerebral ischemic attack. Review of the resident's functional capacity screen dated 5-20-19 revealed the resident needed assistance with dressing and had impaired vision and hearing. Review of the resident's negotiated service agreement dated 5-20-19 reviewed the residents wife assisted him with activities of daily living. Review of the resident's record included 2 "neurological flow sheets" which assessed the	S3171		

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S3171	Continued From page 10	S3171		

residents level of consciousness, extremity movements, hand grasp, pupil size and reaction to light, speech, and vital signs. It also included initials of the person who completed the assessment.

During an interview on 8-12-19 at 3:23 PM certified staff D confirmed her initials were on the form and reported the certified aides completed the assessment and that no one had really shown her how to do it. Certified staff D stated the assessment was completed on residents who had fallen and hit their head. Stated she just looked at their eyes and they looked the same, had the resident hold her hands and squeeze them.

During an interview on 8-13-19 at 7:54 AM certified staff C reported the certified staff fill out the assessment forms when a resident hit their heads. Staff C stated the nurses told the certified staff what to do and the form had directions on how often to do the assessment. Staff C also stated she felt more comfortable with the nurses doing the assessment.

During an interview on 8-13-19 at 3:15 PM administrative staff B reported the certified staff were not to be completing the neurological assessment when a resident fell. Administrative staff B reported the certified staff needed to complete the ********** form.

The administrator failed to ensure all health care services were provided to residents by qualified staff for 2 (#812 and #822) of 3 residents in accordance with acceptable standards of practice related to the performance of neurological assessment after the resident's had a fall and hit their head

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S3175 SS=E	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 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 14 residents. The sample included 3 residents and 1 focused record review. Based on record review and interview the administrator failed to ensure a licensed nurse completed a self administration assessment for medications for 2 (#812 and #842) of 3 residents to ensure their ability to safely administer their own medications. Resident #812 did not have the assessment completed annually and resident #842 did not have the assessment completed before initially beginning self-administration of medications.	S3175		

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S3175	Continued From page 12 Findings included: - Review of resident #812's record revealed he/she admitted to the home on 5-4-18 with diagnosis of reflux disease, diabetes mellitus type 2 and primary osteoarthritis. Review of the resident's functional capacity screen dated 5-21-19 revealed the resident was independent with management of medications and medical treatments. Review of the resident's negotiated service agreement dated 5-21-19 revealed the resident was independent with administration of medications and treatments. Review of the resident's record revealed he/she had a self-administration assessment completed on 5-4-18 and lacked evidence of another one being completed annually. - Review of resident # 842's record revealed he/she admitted to the facility on 5-31-19 with diagnoses of hypertension, heart disease, hypothyroidism. The residents functional capacity screen dated 5-20-19 revealed the resident was independent with the management of his/her medications. Review of the residents negotiated service agreement dated 5-31-19 revealed the resident self-administered his/her medications. Review of the residents medical record lacked evidence that a licensed nurse completed an assessment to ensure the resident could safely administer his/her own medications.	S3175		

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S3175	Continued From page 13 During an interview on 8-13-19 at 1:40 PM administrative staff B reported according to the facilities policy the nurse needed to complete a self-administration assessment for residents who self-administered their medications quarterly. The administrator failed to ensure a licensed nurse completed a self-administration assessment for medications for 2 (#812 and #842) of 3 residents to ensure their ability to safely administer their own medications.	S3175		
S3211 SS=F	26-41-205 (g) (3) OVER THE COUNTER DRUGS (3) A licensed nurse or medication aide may accept over-the-counter medication only in its original, unbroken manufacturer ' s package. A licensed pharmacist or licensed nurse shall place the full name of the resident on the package. If the original manufacturer ' s package of an over-the-counter medication contains a medication in a container, bottle, or tube that can be removed from the original package, the licensed pharmacist or a licensed nurse shall place the full name of the resident on both the original manufacturer ' s medication package and the medication container. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(g)(3) The facility reported a census of 14 residents. Based on observations and interview the administrator failed to a licensed pharmacist or licensed nurse placed the full name of the	S3211		

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S3211	Continued From page 14 resident on all over the counter medications. This had the potential to affect all residents. Findings included: - During initial tour on 8-12-19 at 10:58 AM the following over the counter medications were in the med carts without the residents full name on the bottle. The even room # cart had 2 boxes of acid reducer medication, a bottle of Ibuprofen, and 2 boxes of Omeprazole that did not have the full name of the resident on it. The odd numbered medication cart contained a bottle of Systane I caps and a bottle of Omega 3 that did not have the resident's full name on the bottle. As the surveyor and certified staff A went through the medication carts certified staff A proceeded to write the full name of the resident on each bottle. The administrator failed to ensure a licensed pharmacist or licensed nurse placed the full name of the resident on all over the counter medications.	S3211		
S3227 SS=D	26-41-205 (l) (2) Medication Regimen Review Variance Report (l) (2) The licensed pharmacist or licensed nurse shall notify the medical care provider upon discovery of any variance identified in the medication regimen review that requires immediate action by the medical care provider. The licensed pharmacist shall notify a licensed nurse within 48 hours of any variance identified in the resident ' s regimen review that does not require immediate action by the medical care provider and specify a time within which the licensed nurse must notify the resident ' s medical care provider. The licensed nurse shall	S3227		

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S3227	Continued From page 15 seek a response from the medical care provider within five working days of the medical care provider ' s notification of a variance. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(l)(2) The facility reported a census of 14 residents. The sample included 3 residents and 1 focused record review. Based on interview and record review the administrator failed to ensure the licensed nurse notified the resident's medical care provider of any variance identified by the pharmacist and failed to seek a response from the medical care provider within five working days of the medical care provider's notification of a variance for 1 (#832) of 3 sampled residents. Findings included: - Review of resident #832's record revealed the resident admitted to the facility on 9-19-15 with diagnosis of nausea, constipation, dermatitis, reflux disease, heart failure, anxiety, and right arm pain. Review of the resident's functional capacity screen dated 5-25-19 revealed the resident needed physical assistance with bathing and dressing and supervision with toileting. The resident was frequently incontinent of bladder and had impaired cognition and vision. The resident also required physical assistance with medication and treatment management. Review of the negotiated service agreement dated 5-25-19 revealed 1 staff person assisted	S3227		

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S3227	Continued From page 16 the resident with bathing 3 times per week and assisted the resident with dressing. The staff administered all medications to the resident. Review of the resident record revealed the pharmacist made the following recommendations: 11-18-18 - to decrease the residents Ambien from 10 milligrams (mg) to 5 mg. 5-29-19 - to discontinue the Prilosec and start Pepcid 20 mg daily or decrease Prilosec to 20 mg daily or write a risk verses benefit statement if no change in order. The resident's record lacked evidence that either of these recommendations were sent to the medical provider and/or a response to the recommendations was sought by the nurse in 5 days after notifying the physician. The administrator failed to ensure the licensed nurse notified the resident's medical care provider of any variance identified by the pharmacist and failed to seek a response from the medical care provider within five working days of the medical care provider's notification of a variance for 1 (#832) of 3 sampled residents	S3227		
S3229 SS=E	26-41-205 (l) (4) Medication Regimen Review Self Administration (l) (4) The administrator or operator, or the designee, shall offer each resident who self-administers medication a medication regimen review to be conducted by a licensed pharmacist at least quarterly and each time a resident experiences a significant change in condition. A licensed nurse shall document the resident ' s decision in the resident ' s clinical record.	S3229		

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S3229	Continued From page 17 This REQUIREMENT is not met as evidenced by: KAR 26-41-205(l)(4) The facility reported a census of 14 residents. The sample included 3 residents and 1 focused record review. The administrator failed to offer 3 (#812, #822, #842) of 4 residents who self-administered medication a medication regimen review conducted by a licensed pharmacist at least quarterly and each time a resident experienced a significant change in condition. A licensed nurse shall document the resident's decision in the resident's clinical record. Findings included: - Review of resident #812's record revealed he/she admitted to the home on 5-4-18 with diagnosis of reflux disease, diabetes mellitus type 2 and primary osteoarthritis. Review of the resident's functional capacity screen dated 5-21-19 revealed the resident was independent with management of medications and medical treatments. Review of the resident's negotiated service agreement dated 5-21-19 revealed the resident was independent with administration of medications and treatments. - Review of resident #822's record revealed he/she admitted to the facility on 5-31-19 with diagnosis of hypertension and cerebral ischemic attack. Review of the resident's functional capacity	S3229		

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S3229	Continued From page 18	S3229		

screen dated 5-20-19 revealed the resident required physical assistance administration of medications.

Review of the negotiated service agreement dated 5-31-19 revealed the resident's spouse gave the resident his/her medications.

- Review of resident # 842's record revealed he/she admitted to the facility on 5-31-19 with diagnoses of hypertension, heart disease, hypothyroidism.

The residents functional capacity screen dated 5-20-19 revealed the resident was independent with the management of his/her medications.

Review of the residents negotiated service agreement dated 5-31-19 revealed the resident self-administered his/her medications.

Review of each residents nurse's notes lacked evidence staff offered the resident the option to have his/her medications reviewed by a licensed pharmacist.

Review of the pharmacy review reports from 5-16-18 to 5-27-19 lacked evidence the pharmacist reviewed the resident's medication regimen.

During an interview on 8-13-19 at 11:12 AM administrative staff B reported a resident who self-administered their own medications should have been offered a pharmacy review of medications.

The administrator failed to ensure residents who self-administered their medications were offered the opportunity to have a licensed pharmacist

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S3229	Continued From page 19 review their medications.	S3229		
S3298 SS=F	26-41-206 (d) Food Preparation (d) Food preparation. Food shall be prepared using safe methods that conserve the nutritive value, flavor, and appearance and shall be served at the proper temperature. (1) Food used by facility staff to serve to the residents, including donated food, shall meet all applicable federal, state, and local laws and regulations. (2) Food in cans that have significant defects, including swelling, leakage, punctures, holes, fractures, pitted rust, or denting severe enough to prevent normal stacking or opening with a manual, wheel-type can opener, shall not be used. (3) Food provided by a resident ' s family or friends for individual residents shall not be required to meet federal, state, and local laws and regulations. This REQUIREMENT is not met as evidenced by: KAR 26-41-206(d) The facility reported a census of 14 residents. The sample included 3 residents and one focused resident record review. The administrator failed to ensure staff prepared food using safe methods that conserve the nutritive value, flavor and appearance and shall be served at the proper temperature as evidenced by interview and record review affecting all residents. Findings included:	S3298		

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S3298	Continued From page 20 - Observation during entrance tour with dietary staff E on 8-13-19 at 11:24 AM revealed a small steamer, microwave, and gas stove and oven. Requested food temperature logs. Review of the food temperature logs revealed multiple menus that included the day of the week but not the date. There were a total of 42 days or 126 meals. The record had food temperatures logged for only 13 meals. On 8-12-19 at 11:24 AM dietary staff E reported all the food except for breakfast and deserts are prepared in the main kitchen and brought to the assisted living in a hot food cart. dietary staff are then supposed to put the food in the steam table and take the temperature of all food items to make sure the right temperature. For all residents, the administrator failed to ensure staff prepared food using safe methods that conserve the nutritive value, flavor and appearance and shall be served at the proper temperature	S3298		
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	S3310		

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S3310	Continued From page 21 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: K.A.R 26-41-207(c) The facility reported a census of 14 residents. The sample included 3 residents and 1 focused record review. Based on interview and record review for 3 (#812,#822,#842) of 4 residents and 1 of 2 newly employed staff, the administrator 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. Findings included: - Review of resident #812's medical record revealed he/she admitted to the facility on 5-4-18 with diagnoses of reflux disease, diabetes mellitus type 2, and primary osteoarthritis. Review of the medical record revealed the resident received an initial TB skin test on 8-27-18, more than 3 months after admission to the facility. - Review of resident #822's medical record revealed he/she admitted to the facility on 5-31-19 with diagnoses of hypertension, cerebral ischemic attack and ocular manifestations related to vitamin A deficiency. Review of the medical record revealed the	S3310		

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S3310	Continued From page 22 resident received lacked evidence the resident received a tuberculosis skin test or questionnaire upon admission to the facility. - Review of resident #842's medical record revealed he/she admitted to the facility on 5-31-19 with diagnoses of hypertension, heart disease, and hypothyroidism. Review of the medical record lacked evidence the resident received a tuberculosis skin test or questionnaire upon admission to the facility. During an interview on 8-13-19 at 3:00 PM administrative staff B reported he/she did not find evidence of TB testing in the resident records. - Review of Certified staff E's employee record included a tuberculosis questionnaire but lacked evidence of completion of a tuberculosis skin test. During an interview on 8-13-19 at 9:27 AM administrative staff B reported the staff did not complete a TB skin test of certified staff E. The administrator 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 for 1 new employee and 3 residents.	S3310		