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	N006001	A. BUILDING: _____ B. WING _____	09/20/2018

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GUEST HOME ESTATES VI	737 HEYLMAN STREET FORT SCOTT, KS 66701

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S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey with a complaints (#121773, #122537, #133195, #133329, #133308, #133306) at the above named assisted living facility conducted on 9/17,18,19,20/2018.	S 000		
S3026 SS=J	26-41-101 (f) (1) Staff Treatment of Residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f)(1)(B) The facility reported a census of 36 residents. The sample included 4 residents and 2 focused reviews. Based on observation, interview, and record review for 1 (#917) of 4 residents sampled the operator failed to ensure the resident was not subjected to neglect when a resident identified as an elopement risk, who had a history of elopement and poor decision making walked out the north exit door at approximately 12:10 AM and was unaccounted for by staff for at least 40 minutes. The resident was found by local citizens who notified the police at 12:48 AM. The police found the resident 4 blocks away from the facility. The resident was returned to the facility by certified staff I at 1:07 AM with local police	S3026		

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

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assistance. This failure placed the resident in immediate jeopardy for harm, injury or death.

Findings included:

- Review of resident #917's medical record revealed an admission date of 11/1/16 with diagnosis of Dementia, glaucoma, and Syncope.

Review of the Functional capacity screen dated 10/10/17 revealed the resident needed physical assistance with activities of daily living, had bladder incontinence and poor short-term memory, memory/recall ability and poor decision making. The resident was at risk for falls and unsteadiness.

Review of the Negotiated service agreement dated 10/10/17 lacked identification of the resident's ability to leave the facility without supervision, interventions for restlessness/hallucinations/delusions and elopement risk.

Review of the resident's quarterly elopement risk assessments from 11/1/17 to 8/1/18 revealed a score of 12 indicating the resident had a risk of elopement and prevention protocols should be followed and documented on the care plan.

Review of the nurse's notes recorded the following:
10/19/17 - 3:00 PM administrative/nursing staff L noted the resident confused, stands at the door and wants to go home. Cries when he/she realizes spouse is deceased.
10/28/17 (no time) - administrative/nursing staff L noted the resident not sleeping, remains confused, actively trying to leave, hallucinating. New order received for trazadone .25 mg three

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times a day.
10/31/17 (no time)- administrative/nursing staff L noted the resident remains confused and lost - stood at nurse's desk for hour and packed clothing in a box to go home.
9/7/18 - 12:10 - administrative staff E noted Alarm on door sounded and resident had walked out of the north door. Staff went outside to look for resident but could not find him/her. Staff notified police that resident was missing, and staff was told the police already had the resident in their care. The resident returned to facility without injury. The operator was notified along with responsible party. (per interview with administrative staff E on 9/18/18 at 6:33 AM he/she found out about the elopement at approximately 1L00 AM and staff told him/her the resident was find so he/she did not come in until about 6:00 am that morning)
9/10/18 (no time), administrative staff E noted Plan of care discussion with case manager, responsible party and RN/operator.
9/12/18 (no time), administrative staff E noted Resident up for breakfast with assistance.
9/13/18 (no time) psychologist to see resident with noted decline in activity will continue through disease process.
9/14/18 (no time) Resident sleep today, makes verbalizations but did not open eyes.
9/17/18 (no time) Resident had 6 days of trazadone (antidepressant) 100 mg and is very sleepy. Does not attempt to get up and walk.

Review of the police report revealed officers were dispatched to the 700 block of Lowman Street, 4 blocks away from the facility at 12:48 AM. Police arrived on the scene at 12:51 AM. The report indicated 2 local citizens saw the resident wandering around near their back yard, so they helped the resident and called local police. The

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report noted the facility staff contacted the police department to report a missing resident and the call came in after the police were already with the resident. (41 minutes after staff I reported the alarm sounded) Police contacted the facility and gave them the address of where they could get the resident. Police followed staff to the facility and gathered statements of certified staff I and then left the facility.

Review of a written statement from certified staff I revealed the resident had been at the nurse's station at approximately 11:40 PM. At approximately 12:05 AM the resident said he/she was going to bed. At 12:10 AM the north door alarm sounded and staff I yelled at certified staff J and then went out the front door with a flashlight and staff J went out the north hall door. Staff looked around and did not see the resident and so Staff I got into his/her pickup and went looking for the resident. Staff I wrote he/she looked in a 4-block area, could not find the resident and then returned to the facility and called the police. Staff I wrote when he/she called the police they told him/her the police were already with the resident. The officer then called staff I back and told him/her where the resident was and to come and get the resident. The officer helped get the resident into the pickup and then followed them to the facility. Staff I reported they did 45-minute checks on the resident throughout the night. The certified staff I wrote the resident returned unharmed.

Review of certified staff J's written statement revealed the resident was in bed when he/she came on duty at 10:00 PM. Staff J reported he/she was in the dining room when the alarm sounded and certified staff I was at the nurse's station. Staff J ran down the north hall and staff I

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got a flashlight and went out the front door. By the time staff J got to the north door and looked outside, the resident was gone. Staff I got into his/her truck and drove around looking for her and staff J walked around the building and could not find the resident. Staff J then came inside and started a room to room search. When staff I returned to the facility he/she called the police and they called back and staff I went to go get the resident.

Observation of the building revealed the front is approximately 12 feet from the nurses station, where staff I was, and the north door is approximately 130 feet from the dining room where staff J was when the alarm sounded.

Observation of the building area around the facility on 9/17/18 at 11:42 AM revealed outside of the north exit door was a sidewalk that went to the west side of the building which leads to the front parking lot where licensed nursing staff I reported he/she went when the alarm sounded. Directly in front of the exit door about 5 feet is a steep hill down into the neighbors back yard and there is no sidewalk that leads to the west side of the building / back parking area. The building had lights on the east side and a flood light on the end of the north side of the building. The streets through a residential neighborhood from the facility to the address approximately 0.5 miles away where police found resident #917 lacked sidewalks and most only had street lights at the corner of intersecting streets.

Review of Wunderground.com recorded the temperature on 9/7/18 at 12:15 a.m. as 74 degrees with calm winds and 100% humidity.

Observation on 9/17/18 at 11:05 AM upon arrival

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to the facility surveyor walked into the front door and there was no alarm that sounded. While standing at the nurses station 3 different times people went in and out of the front door without an alarm sounding. At 11:32 AM on 9/17/17 observation of the alarm panel revealed the front door, laundry and patio switches were flipped down to the off position.

Observation on 9/17/18 at 5:15 PM certified staff A walked the resident to the dining room holding onto the residents left upper arm and left hand. The resident had a shuffled gait while walking.

Observation on 9/18/18 at 11:45 AM staff propelled the resident to the table using a wheelchair. The resident sat with his/her head hanging down and leaning to the right.

During an interview on 9/17/18 at 2:43 PM certified staff C reported about a month ago the resident went out the front door and by the time staff C got to the resident he/she was walking down the sidewalk.

During an interview on 9/17/18 at 3:36 PM certified staff A reported the resident currently could walk independently at times and other times he/she needed staff assistance.

During an interview on 9/18/18 at 5:06 AM certified staff H reported the resident needs more help than he/she did last month. Prior he/she walked independently without any problems and now he/she can walk independently but not safely. Stated the resident had gone out the front door before and would sit on the bench right out front but had not left the grounds before.

During an interview on 9/18/18 at 5:30 AM

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certified staff J reported for residents at risk for elopement staff needed to keep a close eye on them and not let them outside when their mood changed.

During an interview on 9/17/18 at 1:53 PM administrative staff E reported the resident had a sitter with him/her for 3 nights after the elopement and staff kept the resident in sight during the day. The resident's medications were increased and staff training on the alarms was conducted to make sure the alarms are always on. Administrative staff E also reported the area out the north door is very dark at night and the trees have been trimmed to allow more lighting so the hill outside the north door could be seen. Staff E also reported according to the policy staff needed to be doing 30-minute checks for residents at risk for elopement.

Review of the elopement policy revealed residents who scored more than a 10 either needed monitored every 30 minutes or one-on-one supervision until they are no longer a flight risk.

The record lacked evidence of 30-minute checks for residents at risk for elopement and lacked evidence resident #917 had a sitter during night shift for 3 nights after the elopement. The record lacked interventions to address elopement risk and prevent recurrence of elopement.

For resident #917 the operator failed to ensure the resident was not subjected to neglect when the resident, who was identified as an elopement risk, had a history of elopement and poor decision making walked out the north exit door and was found by community members over 40 minutes later approximately .5 miles from the facility. This

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S3026	Continued From page 7 failure placed resident #917 in immediate jeopardy for harm, injury or death. The immediate jeopardy was removed on 9/17/18 at 5:10 PM when administrative staff E provided a plan for prevention of recurrence of elopement for this resident or any other resident identified at risk for elopement. The plan included the following. 1. Keep alarms on 100 % of the time. 2. Move resident to a room down the west hall where he/she would be visible from the desk. 3. Keep resident involved in activities. 4. Keep the area well-lit outside . 5. Make every hour bed checks. 6. In-service all staff on the elopement policy. 7. Put "stop" signs on the exit doors 8. Re-train staff 9. Check monitoring (alarm) system routinely 10. Increase staff as needed. (Staff E also reported if a resident was trying to leave or agitated he/she wanted staff to stay with that resident and have the other staff person contact staff E to come and help.)	S3026		
S3171 SS=D	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 36 residents. The sample included 4 residents and 2 focused	S3171		

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reviews. Based on interview and record review the operator failed to ensure licensed staff completed wound dressing changes for 1 (#919) of 4 sampled residents according to acceptable standards of practice.

Findings included:

- Review of resident #919's medical record revealed the resident admitted to the facility on 3/5/18 with diagnosis of hypertension, chronic kidney disease, depression and diabetes.

Review of the functional capacity screen dated 7/3/18 revealed the resident could not manage his/her own medications or medical treatments.

Review of the negotiated service agreement dated 7/3/18 revealed facility staff would manage the residents medications and medical treatments for the resident.

Review of the Hospice chart revealed an order dated 9/7/18 for the following dressing changes: Right heel with open blister, cleanse, apply skin prep and cover with Maxorb AG and Sorbex (a type of wound dressing). Use medipore tape to secure and wrap in kerlix. Change dressing daily and as needed. The left heel also had an open blister and had the same dressing change order.

Review of the resident record lacked evidence of facility staff completing the dressing changes daily as ordered.

During an interview on 9/18/18 at 3:00 PM licensed hospice nurse reported the hospice nurse changed the resident's dressing twice a week and the facility nurse changed it on the other days.

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S3171	Continued From page 9 During an interview on 9/18/18 at 3:15 PM administrative nursing staff E looked through the residents chart for evidence of dressing changes and could not find it. Staff E reported the nurses should have documented changing the residents dressings on the medication administration record. The operator failed to ensure designated staff completed dressing changes according to acceptable standards of practice.	S3171		
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 36 residents. The sample included 4 residents and 2 focused reviews. Based on observation and interview,	S3211		

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S3211	Continued From page 10 administrative staff E failed to ensure designated staff labeled over the counter medications with the resident's full name. Findings included: - Observation on 11:12 AM observation of the south medication cart with licensed nursing staff D revealed 4 bottles of nasal spray with resident initials and 1 bottle without any resident identification on it. The cart also contained a bottle of stool softener 100 mg staff E stated was used for "stock" (multiple resident use), and a bottle of B12 1000 mg without a resident name on it. The north medication cart had a drawer with the following over the counter medications without a resident name on them: womans health vitamin, vitamin C, Vitamin B12, Iron 325 mg, Melatonin 3 mg and an over the counter vision tablet. Interview on 9/1718 at 11:13 AM Licensed Nursing Staff D stated the stool softener was a "stock medication" and used for any resident who had an order but did not have their own medication. Facility policy for "Medication Administration" revealed over the counter medications would have the residents full name on the package. The operator failed to ensure all over the counter medications had the resident's full name.	S3211		
S3215 SS=F	26-41-205 (h) Medication Storage (h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in	S3215		

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S3215	Continued From page 11 accordance with each manufacturer ' s recommendations or those of the pharmacy provider and with federal and state laws and regulations. (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the facility in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the facility in separately locked compartments within a locked medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals. (2) Each resident managing and self-administering medication shall store medications in a place that is accessible only to the resident, licensed nurses, and medication aides. (3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy provider may request that the medication be stored by the facility. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(h)(1) The facility reported a census of 36 residents. The sample included 4 residents and 2 focused reviews. Based on observation and interview the operator failed to ensure designated staff stored	S3215		

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S3215	Continued From page 12 controlled medications managed by the facility in separately locked compartment within a locked medication room. This failure had the potential to affect all residents. Findings included: - Observation on 9/18/17 at 7:02 AM with certified staff H revealed a cabinet with a lock on it that was unlocked. Staff H reported the narcotics are kept in the cabinet to be destroyed with the other medications. During an interview on 9/18/18 at 7:10 AM administrative staff E reported the cabinet needed to be locked at all times. Review of the medication administration policy included storage procedures which revealed medications managed by the facility would be stored according to federal and state laws and regulations. The operator failed to ensure controlled medications ready to be destroyed were stored separately locked compartment within the locked med room.	S3215		
S3216 SS=F	26-41-205 (i) Disposition of Medication (i) Accountability and disposition of medications. Licensed nurses and medication aides shall maintain records of the receipt and disposition of all medications managed by the facility in sufficient detail for an accurate reconciliation. (1) Records shall be maintained documenting the destruction of any deteriorated, outdated, or discontinued controlled medications and biologicals according to acceptable standards of	S3216		

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S3216	Continued From page 13 practice by one of the following combinations: (A) Two licensed nurses; or (B) a licensed nurse and a licensed pharmacist. (2) Records shall be maintained documenting the destruction of any deteriorated, outdated, or discontinued non-controlled medications and biologicals according to acceptable standards of practice by any of the following combinations: (A) Two licensed nurses; (B) a licensed nurse and a medication aide; (C) a licensed nurse and a licensed pharmacist; or (D) a medication aide and a licensed pharmacist. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(i)(1) The facility reported a census of 36 residents. The sample included 4 residents and 2 focused reviews. Based on interview and record review the operator failed to ensure proper accountability and disposition of medications by the failure to count controlled medications to be destroyed and failure to maintain documentation of the destruction of medications according to acceptable standards of practice. This failure had the potential to affect all residents. Findings included: - Observation on 9/18/17 at 7:02 AM with certified staff H revealed a cabinet with a lock on it that was unlocked. Staff H reported the narcotics and other medications to be destroyed were kept in the cabinet. Controlled medications included:	S3216		

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S3216	Continued From page 14 2 cards with Ativan 0.5 mg tablets, 4 bottles of morphine sulfate liquid, 2 cards of MS Contin 15 mg, 6 Fentanyl patches and 2 cards of Tramadol. During an interview on 9/18/18 at 7:03 AM certified staff H reported he/she did not count the narcotics in the cabinet. During an interview on 9/18/19 at 7:10 AM administrative staff E reported staff should have been counting the controlled medications. Review of the disposition of medication revised on 8/13/13 revealed narcotics pending disposition will be held with other narcotics and counted each shift change. - Review of the discontinued log provided by administrative staff E revealed a form that listed discontinued medications but failed to identify if the medications were destroyed or returned to the pharmacy. The list included controlled medications and other prescription and over-the-counter medications. On 9/18/18 at 7:30 AM administrative staff E thought the intention of the forms were to identify destroyed medications. Review of the disposition of medication policy revised on 7/9/13 revealed records would be maintained of the disposition of all substances managed by the facility so there could be an accurate reconciliation. The operator failed to ensure designated staff counted narcotic medications and maintained accurate disposition of discontinued medications.	S3216		

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S3225	Continued From page 15	S3225		
S3225 SS=E	26-41-205 (l) Medication Regimen Review Frequency (l) Medication regimen review. A licensed pharmacist shall conduct a medication regimen review at least quarterly for each resident whose medication is managed by the facility and each time the resident experiences any significant change in condition. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(l) The facility reported a census of 36 residents. The sample included 4 residents and 2 focused reviews. Based on record review and interview the operator failed to ensure a licensed pharmacist conducted a medication regimen review at least quarterly for 2 (#917 and #920) of 4 whose medications were managed by the facility. Findings included: - Review of resident #917's medical record revealed an admission date of 11/1/16 with diagnosis of Dementia, glaucoma, and Syncope. Review of the Functional capacity screen dated 10/10/17 revealed the resident could not manage	S3225		

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S3225	Continued From page 16	S3225		

his/her own medications or medical treatments.

Review of the negotiated service agreement identified staff provided medication management for the resident.

Review of the pharmacy medication regimen reviews revealed the pharmacist reviewed the residents medication regimen on 7/6/17, 10/24/17, 1/29/18 and 6/17/18. The record lacked a regimen review for 4/2018.

- Review of resident #920's record revealed he/she admitted to the facility on 113/17 with diagnosis of chronic diarrhea, hypertension, chronic obstructive pulmonary disease, and anxiety.

Review of the functional capacity screen dated 11/3/17 revealed the resident could not manage his/her own medications and medical treatments.

Review of the negotiated service agreement dated 11/3/17 revealed staff provided total assistance with medications and medical treatments.

Review of the pharmacist medication regimen reviews revealed the pharmacist reviewed the residents medication regimen on 1/29/17 and 6/17/18. The record lacked evidence of quarterly reviews.

During an interview on 9/19/18 at 9:07 AM administrative staff E reported he/she knew the pharmacy reviews were behind when he/she started working.

The operator failed to ensure pharmacy medication regimen reviews were conducted

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S3225	Continued From page 17 quarterly.	S3225		
S3245 SS=F	26-41-102 (a) Staff Qualifications Sufficent Staff (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the provision of a sufficient number of qualified personnel to provide each resident with services and care in accordance with that resident ' s functional capacity screening, health care service plan, and negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-41-102(b) The facility reported a census of 36 residents. The sample included 4 residents and 2 focused reviews. Based on interviews and record review for this assisted living facility and affecting all residents who resided in the facility the operator failed to ensure direct care staff or licensed nursing staff were in attendance at the facility at all times. Findings included: - Review of the residents roster provided by facility staff revealed 9 residents required assistance of 2 staff for transfers. Review of certified staff J's written statement revealed when staff J and certified staff I identified a resident had left the facility without supervision at 12:10 AM Staff I went our the front door of the building to look for the resident and	S3245		

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S3245	Continued From page 18 staff I went out the North hall door. Staff J wrote in his/her statement when they could not find the resident staff I left the facility in his/her pickup and staff J walked around the building and didn't see anyone so he/she came back into the building. Review of staff I's written statement revealed staff I went out the front door to look for a resident who left without supervision and when he/she could not find the resident staff I got in his/her truck and left to go look for the resident. The written statement revealed staff J was gone from the facility for approximately 5 minutes. The operator failed to ensure direct care staff or licensed nursing staff were in attendance at the facility at all times.	S3245		
S3261 SS=D	26-41-105 (f) (11) Resident Record Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action This REQUIREMENT is not met as evidenced by: KAR 26-41-105(f)(11) The facility reported a census of 36 residents. The sample included 4 residents and 2 focused reviews. Based on record review and interview the operator failed to document all incidents, time of occurrence, action taken and the results of the action for 1 (#917) of 4 sampled residents.	S3261		

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S3261	Continued From page 19 Findings included: - Review of resident #917's medical record revealed an admission date of 11/1/16 with diagnosis of Dementia, glaucoma, and Syncope. Review of the Functional capacity screen dated 10/10/17 revealed the resident needed physical assistance with activities of daily living, had bladder incontinence and poor short-term memory, memory/recall ability and poor decision making. The resident was at risk for falls and unsteadiness. Review of the Negotiated service agreement dated 10/10/17 lacked identification of the resident's ability to leave the facility without supervision, interventions for restlessness/hallucinations/delusions and elopement risk. Review of the nurses notes revealed the following: 9/7/18 - (12:10) - Alarm on door sounded and resident had walked out of the north door. Staff went outside to look for resident but could not find him/her. Staff notified police that resident was missing, and staff was told the police already had the resident in their care. The resident returned to facility without injury. The operator was notified along with responsible party. The documentation lacked action to prevent recurrance of the elopement and the results of any such action taken. It also neglected to include a nursing assessment of the resident to identify any possible injuries or other trauma related to being out of the facility.	S3261		

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S3261	Continued From page 20 During an interview on 9/17/18 at 2:43 PM certified staff C reported about a month ago the resident went out the front door and by the time staff C got to the resident he/she was walking down the sidewalk. The record lacked evidence of the resident leaving the facility as reported by staff C. The operator failed to document all incidents, time of occurrence, action taken and the results of the action for resident #917 when he/she eloped from the facility.	S3261		
S3280 SS=F	26-41-104 (d) Disaster and Emergency Preparedness (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the facility ' s emergency management plan; (2) education of each resident upon admission to the facility regarding emergency procedures; (3) quarterly review of the facility ' s emergency management plan with employees and residents; and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location. This REQUIREMENT is not met as evidenced by:	S3280		

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S3280	Continued From page 21 KAR 26-41-104(d)(3) The facility reported a census of 36 residents. The sample included 4 residents and 2 focused reviews. Based on record review and interview for all residents and all facility employees, the operator failed to ensure disaster and emergency preparedness by ensuring performance of quarterly review of the facility's emergency management plan with employees and residents. Findings included: - Review of the resident council minutes for review of the disaster plan revealed quarterly reviews at the resident council meetings. However, it failed to review the disaster plan with residents who did not attend the resident council meetings. During an interview on 9/19/18 at 10:26 AM administrative staff E reported in order to ensure would have had to do individual reviews with residents and to his/her knowledge that had not been done. - Review of the quarterly reviews of the emergency management plan with staff revealed the only review had been conducted on 1/15/18. For all residents and employees, the administrator failed to ensure emergency preparedness by ensuring quarterly review of the emergency management plan with all staff and residents.	S3280		
S3310 SS=F	26-41-207 (b) (5-6) (c) Infection Control Policies (b) (5) prohibiting any employee with a	S3310		

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S3310	Continued From page 22 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: K.A.R 26-207(c) The facility reported a census of 36 residents. The sample included 4 residents and 2 focused reviews. Based on interview and record for 1 (#918) of 4 residents and 1 of 5 new employee records, 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. This failure effected all residents who lived in the residential health care facility. Findings included: - Review of resident #918's record revealed he/she admitted to the facility on 7/23/18 with diagnoses of Parkinson and anxiety. The record revealed the resident received his/her initial first TB skin test on 8/4/18, 11 days after	S3310		

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S3310	Continued From page 23 admission and did not have a TB questionnaire completed. - Review of licensed nursing staff D's record revealed he/she hired onto the facility on 5/11/2017. Staff D's record lacked evidence of TB screening. Review of the tuberculosis (TB) guideline policy revealed each new resident and new employee shall receive a two-step tuberculin skin test within seven days of residency or employment unless certain conditions are met. The operator failed 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. This failure effected all residents who lived in the residential health care facility.	S3310		