STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N050005	A. BUILDING: _____ B. WING _____	05/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARSONS PRESBYTERIAN MANOR	3501 DIRR AVENUE PARSONS, KS 67357

(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 represent the findings of a resurvey for the above named Assisted Living facility conducted on 05/15/23 and 05/16/23.	S 000	Preparation and execution of this plan of correction does not constitue admission or agreement by this provider of the truth of the facts alleged or conclusion set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal or state law. This provider maintains that the alleged deficiencies do not jeopardize the health and safety of residents nor are they of such characteras to limit the provider's capacity to render adequate care. The plan of correction constitutes a written allegation of substantial compliance with State, Federal Medicare and Medicaid requirements. Without waiving the foregoing statement, the provider states the following: The alledged deficiencies and the plan of correction will be provided to the provider's Quality Assurance Committee for review and action on 5/23/23.	
S3081 SS=D	26-41-201 (c) Functional Capacity Screen Reassessment (c) Designated facility staff shall conduct a screening to determine each resident ' s functional capacity according to the following requirements: (1) At least once every 365 days; (2) following any significant change in condition as defined in K.A.R. 26-39-100; and (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-201(c)(1) The facility reported a census of 10 residents. The sample included three residents. Based on interview, and record review the operator failed to ensure designated staff completed a "Functional Capacity Screen" (FCS) for resident (R)101 at least once every 365 days. Findings included: - R101's medical record revealed the resident moved into the facility on 09/30/21 with a diagnosis of Type 2 Diabetes Mellitus.	S3081	Pursuant to the statement alleging a finding that the operator failed to ensure designated staff completed a FCS for one resident at least once every 365 days, the community reviewed its guidelines related to KAR 26-41-201 (c)(1) FCS Reassessment. Corrective action for those residents found to have been affected by the alleged deficient practice: The AL director has supervised the reassessment fo R101 and the development of the FCS. The operator has provided re-education to each staff person responsible to complete a FCS at least once every 365 days. The staff have acknowledged understanding and have demonstrated competency. The AL Director will review FCS's at least quarterly. The community will identify other resident having the potential to be affected by the same alleged deficient practice: The community has identified no other residents as having the potential to be affected by the alleged deficient practice. Measures to prevent re-occurence of the alleged deficient practice: The AL director has provided re-education to each staff person responsible to complete a FCS at least once every 365 days. The staff have acknowledged understaning and demonstrated competency. The AL Director will review FCS's at least monthly to ensure compliance. Actions taken will be reviewed by the Risk Committee at least quarterly. Substantial compliance will be measured by all FCS's being completed in a timely manner. Actions taken will be reviewed by the AQQ Committee at least quarterly. The community will be in substantial compliance by:	6/14/23

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

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S3081	Continued From page 1 Review of R101's medical records revealed the most current FCS was dated 01/11/23 with no documentation to show a FCS was completed in 2022. On 05/16/23 at 11:23 AM Administrative Staff A stated she was not able to locate a FCS completed for R101 for the year 2022. The operator failed to ensure designated staff completed an FCS for R101 at least once every 365 days.	S3081		
S3085 SS=D	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:	S3085	Pursuant to the statement alleging a finding that to operator failed to ensure the NSA was fully developed to include service needs and resident preference for one resident's use of a bed assist device, the community reviewed its guidelines related to KAR 26-41-202 (a) NSA Corrective action for those residents found to have been affected by the alleged deficient practice. The operator has provided re-education to staff related to the NSA to include a description of services the resident will receive, including assistive devices, the identification of each party responsible for payment if outside resources provide a service. Staff have acknowledged understanding and have demonstrated competency. Resident #101's NSA has been updated to include the use of a bed assist device. The AL Director will review NSA's at least monthly for compliance. Actions taken will be reviewed by the Risk Committee at least quarterly. The community will identify other resident have the potential to be affected by the same alleged deficient practice: The community has identified not other residents as having had the potential to be affected by the alleged deficient practice. Measures to prevent re-occurrence of the alleged deficient practice: The AL Director has provided re-education to staff related to the NSA, to include a description of services the resident will receive, including assistive devices, the identification of the provider of each party responsible for payment if outside resources provide a service. Staff have acknowledged understanding and have demonstrated competency. The AL Director will review NSA's at least monthly for compliance. Actions taken will be reviewed by the Risk Committee at least quarterly. Substantial compliance will be measured by all NSA's being completed in a timely manner. Actions taken will be reviewed by the QAA Committee at least quarterly. The community will be in substantial compliance by:	6/14/23

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S3085	Continued From page 2 K.A.R. 26-41-202(a) The facility reported a census of 10 residents with three residents included in the sample. Based on observation, interview, and record review the operator failed to ensure the "Negotiated Service Agreement" (NSA) was fully developed to include service needs and resident preference for resident (R)101's use of a bed assist device. Findings included: - R101's medical record revealed the resident moved into the facility on 09/30/21. The 01/11/23 "Functional Capacity Screen" (FCS) identified R101 was independent with transfers. The 01/11/23 NSA did not address R101's use of a bed assist device. Review of R101's medical records revealed an order dated 12/17/21. May use transfer bar applied to bed as self-positioning device and increase independence. On 05/16/23 at 10:51 AM revealed R101 had a bed assist device properly attached to her bed that was within FDA guidelines. On 05/16/23 at 11:23 AM Administrative Staff A stated R101 utilized a hospital bed with a positioning rail attached and stated she expected the NSA to address the use of a bed assist device.	S3085		

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S3085	Continued From page 3 The operator failed to ensure R101's NSA was fully developed to include the use of a bed assist device.	S3085		
S3092 SS=D	26-41-202 (d) Negotiated Service Agreement Revisions (d) Each administrator or operator shall ensure the review and, if necessary, revision of each negotiated service agreement according to the following requirements:(1) At least once every 365 days; (2) following any significant change in condition, as defined in K.A.R. 26-39-100; (3) at least quarterly, if the resident receives assistance with eating from a paid nutrition assistant; and (4) if requested by the resident or the resident ' s legal representative, facility staff, the case manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-202(d)(1) The facility reported a census of 10 residents. The sample included three residents. Based on interview, and record review the operator failed to ensure the "Negotiated Service Agreement" (NSA) for resident (R)101 was review and revised as needed at least once every 365 days. Findings included:	S3092	Pursuant to the statement alleging a finding that the operator failed to ensure the NSA for one resident was reviewed and revised as needed at least once every 365 days, the community reviewed its guidelines related to 26-41-202 (d) NSA. Corrective action for those residents found to have been affected by the alleged deficient practice: The operator has provided re-education to staff related to the requirement to review resident NSA and revise as needed. The staff have acknowledged understanding and have demonstrated competency. Resident 101's NSA has been reviewed and revised to current needs. The AL Director will review NSA's at least monthly for compliance. Actions taken will be reviewed by the Risk Committee at least quarterly. The community will identify other residents having the potential to be affected by the same alleged deficient practice: The community has identified no other resident's having had the potential to be affected by the alleged deficient practice. Measures to prevent re-occurence of the alleged deficient practice: the AL director has provided re-education to staff related to the requirement to review resident NSA and revise as needed. The staff have acknowledged understanding and have demonstrated competency. The AL Director will review NSA's at least monthly for compliance. Actions taken will be reviewed by the Risk Committee at least quarterly. Substantial compliance will be measured by all NSA's being completed in a timely manner. Actions taken will be reviwed by the AQQ Committee at least quarterly. The community will be in substantial compliance by:	6/14/23

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S3092	Continued From page 4 - R101's medical record revealed the resident moved into the facility on 09/30/21 with a diagnosis of type 2 diabetes mellitus. Review of R101's records revealed the most current NSA was dated 01/11/23 with documentation to show an NSA was completed for the year 2022. On 05/16/23 at 11:23 AM Administrative Staff A stated she was not able to locate an NSA completed for R101 for the year 2022. The operator failed to ensure R101's NSA was reviewed and revised as needed at least once every 365 days.	S3092		
S3101 SS=F	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 10 residents. The sample included three residents. Based on interview, and record review the operator failed to ensure the "Negotiated Service Agreement"	S3101	Pursuant to the statement alleging a finding that the operator failed to the NSA for three residents were signed by all individuals involved int he development of the SNA, the community reviewed its guidelines related to KAR 26-41-202 (h) NSA Signatures. Corrective action for those residents found to have been affected by the alleged deficient practice: The AL Director has supervised the insertions of signatures found missing on the NSA's of resident's 101,102, and 103 The AL Director has provided re-education to staff of the requirement to sign the document The staff have acknowledged understanding and have demonstrated competency. The AL Director will review NSA's for compliance at least monthly. Actions taken will be reviewed by the Risk Committee at least quarterly. The community will identify other resident having the potential to be affected by the same alleged deficient practice: The community will identify other resident having the potential to be affected by the same alleged deficient practice. The community will identify other residents having the potential to be affected by the same alleged deficient practice. Measures to prevent re-occurence of the alleged deficient practice: The AL Director has provided re-education to staff of the requirement to sign the document. The staff have acknowledged understanding and have demonstrated competency. The AL Director will review NSA's for compliance at least monthly. Actions taken will be reviewed by the Risk Committee at least quarterly. Substantial compliance will be measured by all NSA's completed in a timely manner with correct information. Actions taken will be reviewed by QAA Committee at least quarterly.	

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S3101	Continued From page 5 (NSA) for resident (R)101, R102 and R103 were signed by all individuals involved in the development of the NSA. Findings included: - R101's medical record revealed the resident moved into the facility on 09/30/21. The 01/11/23 NSA provided lacked documentation of signatures of all individuals involved in the development of R101's NSA. On 05/16/23 at 11:23 AM Administrative Staff A stated she was not able to locate a signature page for R101's NSA. A policy concerning the NSA was requested on 05/16/23 but none was provided by the facility. The operator failed to ensure R101's NSA was signed by all individuals involved in the development of the NSA. - R102's medical record revealed the resident moved into the facility on 07/18/17. The 05/01/23 NSA provided lacked documentation of signatures of all individuals involved in the development of R102's NSA. On 05/16/23 at 11:23 AM Administrative Staff A stated she was not able to locate a signature page for R102's NSA. A policy concerning the NSA was requested on 05/16/23 but none was provided by the facility.	S3101	The community will be in substantial compliance by	6/14/23

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S3101	Continued From page 6 The operator failed to ensure R102's NSA was signed by all individuals involved in the development of the NSA. - R103's medical record revealed the resident moved into the facility on 09/07/22. The 09/07/22 NSA provided lacked documentation of signatures of all individuals involved in the development of R103's NSA. On 05/16/23 at 11:23 AM Administrative Staff A stated she was not able to locate a signature page for R103's NSA. A policy concerning the NSA was requested on 05/16/23 but none was provided by the facility. The operator failed to ensure R103's NSA was signed by all individuals involved in the development of the NSA.	S3101		
S3186 SS=D	26-41-205 (b) Administration of Selected Medications (b) Administration of select medications. Any resident who self-administers medication may select some medications to be administered by a licensed nurse or medication aide. The negotiated service agreement shall reflect this service and identify who is responsible for the administration and management of selected medications.	S3186	Pursuant to the statement alleging a finding that the operator failed to ensure the NSA for one resident identified the responsible person for administration and management of selected medications administered, the community reviewed its guidelines related to 26-41-205(b), Administration of selected Medications. Corrective action for those residents found to have been affected by the alleged deficient practice. Residents 101's NSA has been updated to include the self-administration of insulin and of the requirement to include all physicians orders/resident preferences related to medication administration in the NSA. The AL Director will review resident NSA at least monthly for accuracy and compliance with the regulation. Actions taken will be reviewed by the Risk Committee at least quarterly. The community will identify other residents having the potential to be affected by the same alleged deficient practice.	

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S3186	Continued From page 7 This REQUIREMENT is not met as evidenced by: KAR 26-41-205(b) The facility reported a census of 10 residents. The sample included three residents. Based on interview, and record review the operator failed to ensure the "Negotiated Service Agreement" (NSA) for resident (R)101 identified the responsible person for administration and management of selected medications administered. Findings included: - R101's medical record revealed she moved into the facility on 09/30/21 with a diagnosis type 2 diabetes mellitus. The 01/11/23 "Functional Capacity Screen" (FCS) documented R101 required staff assistance with medication administration. The 01/11/23 NSA documented staff administered R101's medications and did not identify that R101 self-administered her insulin. Review of the physician orders revealed the following orders: An order dated 12/17/21 for resident will draw up and administer insulin per self. An order dated 12/17/21 for Novolin 70/30 U-100 Insulin 100 unit per milliliter, 37 units subcutaneous, twice daily for diabetes mellitus 2.	S3186	Measures to prevent re-occurence of the alleged deficient practice: The AL director has provided re-education to staff related to resident 101 self-administration of insulin and of the requirement to include all physician orders/ resident preferences related to medication administration in the NSA. The AL Director will review resident NSA at least monthly for accuracy and compliance with the regulation. Actions taken will be reviewed by the Risk committee at least quarterly. Substantial compliance will be measured by all NSA's being completed in a timely manner. Actions taken will be reviewed by the QAA Committee at least quarterly. The community will be in substantial compliance by:	6/14/23

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S3186	Continued From page 8 Hold for blood sugars less than 115. On 05/16/23 at 10:54 AM Licensed Nurse E stated R101 administered her own insulin. On 05/16/23 at 11:23 AM Administrative Staff A stated she expected the NSA to address R101's self-administration of her insulin. The operator failed to ensure designated staff included R101's insulin in the NSA as being self-administered.	S3186		
S3270 SS=F	26-41-104 (b) Written Emergency Plan (b) Each administrator or operator shall ensure the development of a detailed written emergency management plan to manage potential emergencies and disasters, including the following: (1) Fire; (2) flood; (3) severe weather; (4) tornado; (5) explosion; (6) natural gas leak; (7) lack of electrical or water service; (8) missing residents; and (9) any other potential emergency situations. This REQUIREMENT is not met as evidenced by: KAR 26-41-104(b)(5)(6) The facility reported a census of three residents. Based on record review and interview for all	S3270	Pursuant to the statement alleging a finding that the operator failed to ensure the disaster and emergency plan include all required items as it failed to include information on explosion and natural gas leak, the community reviewed it guidelines related to 2KAR 26-41 104(b) Written Emergency Plan. Corrective action for those residents found to have been affected by the alleged deficient practice. The operator has developed a detailed emergency response plan related to an explosion and to a natural gas leak. The community staff have received education related to the expected respond and training at least annually. The staff have acknowledged understanding and have demonstrated competency. Actions taken will be reviewed by the Risk Committee at least quarterly. The community will identify other residents having the potential to be affected by the same alleged deficient practice. The community has identified all residents as having had the potential to be affected by the alleged deficient practice Measures to prevent re-occurrence of the alleged deficient practice: The AL Director has developed a detailed emergency response plan related to an explosion and to natural gas leak. The community staff have received education related to the expected response and will receive training at least annually. The staff have acknowledged under-standing and have demonstrated competency. Actions taken will be reviewed by the Risk Committee at least quarterly. Substantial compliance will be measured by each resident being educated on emergency plan at least quarterly and	

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S3270	Continued From page 9 residents and all facility employees, the operator failed to ensure the disaster and emergency plan include all required items as it failed to include information on explosion and natural gas leak. Findings included: - On 05/15/23 review of documentation of the emergency management plan revealed it did not include information concerning explosion and natural gas leak. On 05/15/23 at 04:16 PM Administrative Nurse D stated the emergency management plan did not include explosions or natural gas leaks. The operator failed to ensure the emergency management plan included all the required items.	S3270	resident will sign off on training. Actions taken will be reviewed by the QAA Committee at least quarterly. The community will be in substantial compliance by:	6/14/23
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	S3280	Pursuant to the statement alleging a finding that the operator failed to ensure disaster and emergency preparedness by ensuring performance of quarterly reviews of the community's emergency management plan with staff and residents and failed to complete an annual evacuation drill for the year 2021, the community reviewed its guidelines related to 23-41-104(d)(3)(4) Disaster and Emergency Preparedness. Corrective action for those resident found to have been affected by the alleged deficient practice. The AL Director has reviewed the undated emergency management plan with residents and staff. The plan will be provided to new admissions/resident representatives upon admission and at least quarterly. A roster of attendees will be maintained and available for review by the Risk Committee at least quarterly. The community will identify other residents having the potential to be affected by the same alleged deficient practice: The community has identified no other residents as having the potential to be affected by the alleged deficient practice.	

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S3280	Continued From page 10 drill shall include evacuation of the residents to a secure location. This REQUIREMENT is not met as evidenced by: 3280 KAR 26-41-104(d)(3)(4) The facility reported a census of 10 residents. 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 reviews of the facility's emergency management plan with staff and residents and failed to complete an annual evacuation drill for the year 2021. Findings included: - On 05/15/23 at 03:54 PM Administrative Nurse D stated Administrative Nurse B reviewed the emergency management plan with the residents when she completed her quarterly assessments. Review of resident medical records revealed quarterly reviews of the emergency management plan were completed in 2022 but there was no documentation of any being completed so far in 2023. On 05/16/23 at 08:16 AM Administrative Staff A stated there was no evacuation drill completed for 2021. Stated staff completed quarterly	S3280	Measures to prevent re-occurrence of the alleged deficient practice : The AL Director has reviewed the updated emergency management plan with residents and staff. The plan will be provided to new employees during orientation and at least annually. The plan will be provided to new admissions/resident representative upon admit and at least annually. A roster of attendees will be maintained and available for review by the Risk Committee at least quarterly. Substantial compliance will be measured by audits being completed showing staff and residents have been educated. Actions taken will be reviewed by the QAA Committee at least quarterly. The community will be in substantial compliance by:	6/14/23

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(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
S3280	Continued From page 11 disaster reviews on the RELIAS computer program. On 05/16/23 documentation of the RELIAS computer training of the emergency management plan completed by staff was requested but the operator did not provide this for review. The operator failed to ensure the performance of quarterly reviews of the emergency management plan with residents and staff and failed to ensure an annual evacuation was completed during 2021.	S3280		
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 This REQUIREMENT is not met as evidenced by: KAR 26-41-207(c)	S3310	Pursuant to the statement alleging a finding that the AL director failed to ensure the community remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in KAR 26-39-105 for one resident and three staff, the community reviewed its guidlelines related to KAR 26-41-207(b) (5-6)(c) Infection control Policies. Corrective action for those residents found to have been affected by the alleged deficient practice. The operator has provided re-education to administrative staff to ensure the TB screening and testing policies are implemented as instruced by the 6/2013 Tuberculosis Guidelines for Adult Care Homes. The staff have acknowledged understanding and have demonstrated competency. The AL Director will review the immunization records for compliance at least weekly. Actions taken will be reviewed by the Risk Committee at least weekly. The community will identify other resident having the potential to be affected by the same alleged deficient practice. The community has identified all residents as having the potential to be affected ty the alleged deficient practice. Measure to prevent re-occurrence of the alleged deficient practice: The operator has provided re-education to administrative staff to ensure the TB screening and testing policies are implemented as instructed by the 6/2013 Tuberculosis Guidelines for Adult Care Homes. The AL Director will review the immunization records for compliance at least weekly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N050005	A. BUILDING: _____ B. WING _____	05/16/2023

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S3310	Continued From page 12 The facility reported a census of 10 residents. The sample included three residents. Based on interview and record review for three residents and three new employee records, the operator failed to ensure the facility remained in compliance with the department's tuberculosis (TB) guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. This failure effected all residents who lived in the assisted living facility. Findings included: - Resident (R)103 moved into the facility on 09/07/22 with a diagnosis of dementia. Review of R103's medical record revealed the first step of the two-step TB skin test (TST) was administered on 09/19/22 which was five days past the seven-day requirement. The "Immunization- Tuberculosis (TB) Testing for Employee Volunteer, and Resident" policy revised 09/07/22 documented, "Administer first PPD in the forearm within one (1) week prior to or one (1) week after admission." The 06/2013 "Tuberculosis (TB) Guidelines for Adult Care Homes" documented, "Each new resident ...shall receive a two-step TST ...within 7 days of residency ..." The operator failed to ensure compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 for one of three residents (R103) reviewed.	S3310	Actions taken will be reviewed by the Risk Committee at least weekly. Substantial compliance will be measured by audits showing all staff and residents are following the Tuberculosis Guidelines. Actions taken will be reviewed by the QAA Committee at least quarterly. The community will be in substantial compliance by:	6/14/23

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	N050005	A. BUILDING: _____ B. WING _____	05/16/2023

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S3310	Continued From page 13 - Review of three newly hired employee files revealed the following: Review of facility personnel records revealed Administrative Nurse B was hired on 02/01/22. Personnel records lacked a TB screening questionnaire completed upon hire and the first step of the two-step TST was not administered till 02/25/22 which was 17 days late. Certified Medication Aide (CMA) C was hired on 06/06/22. Personnel records lacked a TB screening questionnaire completed upon hire and the first step of the two-step TST was not administered till 06/20/22 which was seven days late. Administrative Staff A was hired on 09/06/22. Personnel records lacked a TB screening questionnaire completed upon hire and the first step of the two-step TST was not administered till 09/30/22 which was 17 days late. On 05/15/23 at 01:58 PM Administrative Staff A stated the TB screening questionnaire was completed annually once the staff had worked for a year. The "Immunization- Tuberculosis (TB) Testing for Employee Volunteer, and Resident" policy revised 09/07/22 documented, "At New Hire/Volunteer: 1. Complete individual TB Risk Assessment ...Two-step TB skin test for new employees: a. Testing should be performed within seven (7) days of employment ..." The 06/2013 "Tuberculosis (TB) Guidelines for	S3310		

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	N050005	A. BUILDING: _____ B. WING _____	05/16/2023

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S3310	Continued From page 14 Adult Care Homes" documented, "Each new ...employee shall have an initial TB symptom screen ...within 7 days of ...employment ...Each new ...employee shall receive a two-step TST ...within 7 days of ...employment ..." 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		