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 _____	04/03/2024

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 represent the findings of a resurvey for the above named Assisted Living facility conducted on 04/03/24.	S 000		
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: 3085 KAR 26-41-202(a)(1) The facility reported a census of four 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	S3085		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N034001	A. BUILDING: _____ B. WING _____	04/03/2024

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
S3085	Continued From page 1 developed based on the resident's "Functional Capacity Screen" (FCS), service needs, and preferences for resident (R)102. Findings included: - R102's medical record revealed she moved into the facility on 01/14/21. The 11/07/23 FCS identified R102 was independent with transfers and ambulation and was at risk for falls and had impaired vision. The 11/07/23 NSA did not address what services staff provided R102 concerning falls and impaired vision. On 04/03/24 at 01:06 PM R102 was alert and oriented and independently ambulated in her apartment with the use of a walker. On 04/03/24 at 01:49 PM Administrative Nurse A stated R102's NSA did not address all that triggered on the FCS. The administrator failed to ensure R102's NSA was fully developed to include all items that triggered on the FCS, her service needs, and preferences.	S3085		
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	S3186		

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 _____	04/03/2024

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
S3186	Continued From page 2 negotiated service agreement shall reflect this service and identify who is responsible for the administration and management of selected medications. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(b) The facility reported a census of four residents. The sample included three residents. Based on interview, and record review the administrator failed to ensure the "Negotiated Service Agreement" (NSA) for resident (R)102 identified the responsible person for administration and management of selected medications. Findings included: -R102's medical record revealed she moved into the facility on 01/14/21 with a diagnosis of hypertensive heart disease. The 11/07/23 "Functional Capacity Screen" (FCS) identified R102 required assistance with managing her medications. The 11/07/23 NSA documented staff administered R102's medications. The NSA did not identify that R102 self-administered her nitroglycerin.	S3186		

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 _____	04/03/2024

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
S3186	Continued From page 3 A physician order dated 02/11/21 for Nitrostat tablet, sublingual, give 0.4 milligrams sublingually every five minutes as needed for chest pain times three. Notify nurse if this medication is given. Nurse to notify physician if no relief after three doses. On 04/03/24 at 1:06 PM R102 stated she kept her nitroglycerin in her walker so she could administer it if needed. On 04/03/24 at 01:49 PM Administrative Nurse A stated R102's NSA did not identify R102 self-administered her nitroglycerin as needed. The administrator failed to ensure the NSA identified who was responsible for administration and management of R102's nitroglycerin.	S3186		
S3211 SS=E	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.	S3211		

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 _____	04/03/2024

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
S3211	Continued From page 4 This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (g)(3) The facility reported a census of four residents. Based on observation and interview the administrator failed to ensure a licensed pharmacist or licensed nurse placed the full name of the resident on the original package of over the counter (OTC) medications for three residents. Findings included: - On 04/03/24 at 08:45 AM revealed the facility's medication carts contained the following OTC medications which were not labeled with a resident's full name: Resident (R)101: One bottle of Good Neighbor Pharmacy Pain Relief One bottle of Good Neighbor Pharmacy Allergy Relief R102: One bottle of Good Neighbor Pharmacy Children's Pain & Fever R103: One container of Vicks VapoRub The administrator failed to ensure all OTC medications were labeled by a pharmacist or licensed nurse with the resident's full name.	S3211		

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 _____	04/03/2024

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
S3213	Continued From page 5	S3213		
S3213 SS=E	26-41-205 (g) (2) Medication Labeling (g) (2) Each prescription medication container shall have a label that was provided by a dispensing pharmacist or affixed to the container by a dispensing pharmacist in accordance with K.A.R. 68-7-14. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (g)(2) The facility reported a census of four residents. Based on observation and interview the administrator failed to ensure each prescription medication container had a label provided by a dispensing pharmacist affixed to the container. Findings included: - Observation on 04/03/24 at 08:45 AM revealed the facility's medication carts contained the following prescription medications which were not labeled with a resident's full name: Resident (R)101: One bottle of Neomycin and Polymyxin B Sulfates eyedrops R102: One bottle of Refresh Eye Drops R103: One bottle of Bausch + Lomb Advanced Eye	S3213		

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 _____	04/03/2024

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
S3213	Continued From page 6 Relief Two inhalers of Albuterol Sulfate Inhalation Aerosol One bottle of Major Ear Drops One container of Vicks VapoRub R104: One bottle of Tobramycin-Dexamethasone Ophthalmic Suspension The administrator failed to ensure each prescription medication container had a label provided by a dispensing pharmacist affixed to the container or marked with the resident's full name.	S3213		
S3260 SS=E	26-41-105 (f) (1 - 10) Resident Records Content (f) Each resident record shall contain at least the following: (1) The resident's name; (2) the dates of admission and discharge; (3) the admission agreement and any amendments; (4) the functional capacity screenings; (5) the health care service plan, if applicable; (6) the negotiated service agreement and any revisions; (7) the name, address, and telephone number of the physician and the dentist to be notified in an emergency; (8) the name, address, and telephone number of the legal representative or the individual of the resident's choice to be notified in the event of a significant change in condition; (9) the name, address, and telephone number of the case manager, if applicable; (10) records of medications, biologicals, and	S3260		

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 _____	04/03/2024

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
S3260	Continued From page 7 treatments administered and each medical care provider ' s order if the facility is managing the resident's medications and medical treatments; and This REQUIREMENT is not met as evidenced by: KAR 26-41-105(f)(3) The facility reported a census of four residents. The sample included three residents. Based on interview and record review the administrator failed to ensure two of three sampled resident records contained documentation of a completed admission agreement. Findings included: -Resident (R)101's medical record revealed he moved into the facility on 05/04/18. The 11/17/23 "Functional Capacity Screen" (FCS) documented R101 was cognitively intact and was understood by others and he was able to understand others. Review of R101's medical record failed to locate a completed admission agreement. On 04/03/24 at 01:27 PM Administrative Nurse A stated she was not able to find R101's admission agreement.	S3260		

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 _____	04/03/2024

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
S3260	Continued From page 8 The administrator failed to ensure R101's records contained documentation of a completed admission agreement. -R102's medical record revealed she moved into the facility on 01/14/21. The 11/07/23 FCS documented R102 was cognitively intact and was understood by others and she was able to understand others. On 04/03/24 at 01:49 PM Administrative Nurse A stated she was not able to find R102's admission agreement. The administrator failed to ensure R102's records contained documentation of a completed admission agreement.	S3260		
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.	S3270		

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 _____	04/03/2024

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
S3270	Continued From page 9 This REQUIREMENT is not met as evidenced by: KAR 26-41-104(b)(5)(6)(8) The facility reported a census of four residents. Based on record review and interview for all residents and all facility employees, the operator failed to ensure the disaster and emergency plan included all required items as it failed to include information on missing persons and natural gas leak, and explosion. Findings included: - On 04/03/24 review of the "Disaster and Emergency Policies and Procedures" last updated on 02/15/2019 revealed the following required items were not included: natural gas leak, explosion, missing persons. On 04/03/24 at 09:53 AM Administrative Staff B acknowledged the emergency management plan did not include all required items. The administrator failed to ensure the emergency management plan included all the required items.	S3270		
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	S3280		

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 _____	04/03/2024

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
S3280	Continued From page 10 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: KAR 26-41-104(d)(3) The facility reported a census of four residents. Based on record review and interview for all residents and all facility employees, the administrator 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: - On 04/03/24 at 09:50 AM Maintenance Staff C stated he was not aware that quarterly reviews of the emergency management plan needed to be reviewed with staff and residents and confirmed that quarterly reviews of the emergency management plan had not been completed.	S3280		

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 _____	04/03/2024

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
S3280	Continued From page 11 The administrator failed to ensure the completion of quarterly reviews covering all of the required items of the emergency management plan with employees and residents.	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) The facility reported a census of four residents. Based on record review of three staff records and interview the administrator failed to ensure the facility was in compliance with the department's tuberculosis (TB) guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. Findings included:	S3310		

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 _____	04/03/2024

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
S3310	Continued From page 12 - Review of three staff records revealed the following: "Certified Nurse Aide" (CNA) D was hired on 01/27/23 did not have a two-step TB skin test (TST) completed until 06/28/23 approximately five months past due. CNA E was hired on 05/02/22 did not have a TB Symptom Screening Questionnaire completed until 05/12/22 three days past due and did not have a two-step TST completed until 11/16/22 approximately six months past due. "Certified Medication Aide" (CMA) F did not have a two-step TST completed until 11/07/22 approximately eight months past due. The June 2013 "Tuberculosis (TB) Guidelines for Adult Care Homes" documented, "Each new ...employee shall have an initial TB symptom screen that includes the components of the Tuberculosis Symptom Screen Questionnaire within 7 days of ...employment ...Each new ...employee shall receive a two-step TST or an IGRA for Mycobacterium tuberculosis within 7 days of ...employment ..." The administrator failed to ensure the compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105.	S3310		