STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N021006	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARTEN COUNTRYSIDE HOME INC	2454 HWY 15 NORTH ABILENE, KS 67410

(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 with complaints (#173409 and #167648) at the above named residential healthcare facility conducted on 08/02/22 and 08/03/22.	S 000		
S3081 SS=E	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: KAR 26-41-201 (c) (1) (2) The census equaled 6 residents. The sample included 3 residents and 2 closed record review residents. Based on observation, record review and interview for 3 of 3 sampled residents (R)136, R500, R801, Operator/Licensed Nurse (LN) A failed to ensure designated facility staff conducted a screening once every 365 days and following any significant change in condition as defined in K.A.R. 26-39-100. Findings included:	S3081		

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

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S3081	Continued From page 1	S3081		

- Review of R136's "Medical Record" revealed she admitted to the facility on 04/20/22 with diagnoses of osteoporosis, glaucoma and fibromyalgia.

R136's record lacked a "Functional Capacity Screen."

Interview on 08/03/22 at 08:41 AM with Operator/LN A confirmed R136's record lacked a FCS.

- Review of R500's "Medical Record" revealed he admitted to the facility on 04/21/22 with diagnoses of acute kidney failure, hypertensive heart disease with congestive heart failure, hypotension and atrial fibrillation.

R500's "Functional Capacity Screen" (FCS) dated 04/20/22 recorded resident as independent with dressing, toileting, transfer, walk/mobility and eating, supervision for bathing, physical assistance with management of medications and treatments and continent of bladder. FCS further recorded resident had impaired short-term memory, impaired memory/recall, usually understandable/understood, had impaired vision and hearing, and used a cane for mobility.

Observation on 08/02/22 at 04:11 PM in R500's room revealed resident sitting on couch with wife. R500 had walker by side.

Interview on 08/02/22 at 03:38 PM with Certified Nurse Aide (CNA) C stated R500 gets physical assistance with bathing, dressing, transfer, and walk/mobility. CNA C stated R500 no longer used

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S3081	Continued From page 2 a cane and used a walker for ambulation. R500's FCS lacked a screening upon significant change in status. Interview on 08/03/22 at 04:51 PM with Operator/LN A confirmed R500's current FCS did not reflect his current status and further confirmed the FCS should have been updated. - Review of R801's "Medical Record" revealed she admitted on 03/16/18 with diagnoses of hypertension, diabetes mellitus type 2 and peripheral neuropathy. R801's "Functional Capacity Screen" (FCS) dated 05/13/21 recorded the resident as independent with dressing, toileting, transfer and eating, physical assist required for bathing, walk/mobility, and management of medications and treatments. R801 had impaired short term memory, impaired memory/recall, impaired decision making, usually understandable and sometimes understood. R801 was at risk for falls and had impaired vision. R801's FCS lacked a screening once every 365 days. Interview on 08/03/22 at 12:56 PM with Operator/LN A confirmed R801's current FCS was late. Operator/LN A failed to ensure designated facility staff conduct a screening once every 365 days and following any significant change in condition as defined in K.A.R. 26-39-100.	S3081		

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S3171	Continued From page 3	S3171		
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 census totaled 6 residents. The sample included 3 residents and 2 closed record review resident. Based on observation, interview and record review, Operator/Licensed Nurse (LN) A failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services in accordance with acceptable standards of practice for the use of bed assistive devices, which met the needs of 1 of 3 sampled residents (R) 801. Findings included: - Record review for R801 revealed she admitted on 03/16/18 with diagnoses of hypertension, diabetes mellitus type 2 and peripheral neuropathy. R801's "Functional Capacity Screen" dated 05/13/21 recorded the resident as independent with dressing, toileting, transfer and eating, physical assist required for bathing, walk/mobility, and management of medications and treatments. R801 had impaired short term memory, impaired memory/recall, impaired	S3171		

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S3171	Continued From page 4 decision making, usually understandable and sometimes understood. R801 was at risk for falls and had impaired vision. The resident's "Negotiated Service Agreement" (NSA) dated 05/13/21 recorded R801 was independent with dressing, toileting, transfer and eating and required staff assistance with bathing, walk/mobility. The NSA recorded staff administered medications and treatments. The NSA failed to identify the use of a bed assistive device. The resident's "Resident Care Plan" dated 08/11/21 failed to identify the use of a bed assistive device. Observation on 08/02/22 at 04:23 PM in R801's room revealed a bed cane to the left side of the bed. Bed cane was not secured to bed. R801 confirmed she used the bed cane at times to get out of bed. Interview on 08/03/22 at 12:21 PM with Operator/LN A confirmed no safety checks or bed assistive device assessments completed and further confirmed the bed cane was not secured on R801's bed. Record review lacked any assessment of the resident to confirm the device was not a restraint, an assessment of the resident to determine the purpose of the bedrail/assistive device and the resident's ability to safely use the device, an assessment of the bedrail/assistive device to ensure the device was securely attached to the bed or bedframe and posed no risk for entrapment.	S3171		

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S3171	Continued From page 5 The FDA (food and drug administration) Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment dated 3/10/06 listed 4 zones of greatest concern with specific measurements to reduce the risk of entrapment as follows: Zone 1 within the rail should measure less than 4 and 3/4 inches Zone 2 under the rail, between the rail supports or next to a single rail support should measure less than 4 and ¾ inches Zone 3 between the rail and the mattress should measure less than 4 and 3/4 inches Zone 4 under the rail at the ends of the rail should measure less than 2 and 3/8 inches. Facility's bed assistive devices policy requested on 08/03/22. On 08/03/22 at 12:21 PM, Operator/LN A stated facility does not currently have a policy on bed assistive devices. Operator/LN A failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services which met the needs R801 regarding use of a bed assistive device.	S3171		
S3175 SS=D	26-41-205 (a) (1) Self Administration of Medication (a) Self-administration of medication. Any resident may self-administer and manage medications independently or by using a medication container or syringe prefilled by a licensed nurse or pharmacist or by a family member or friend providing this service	S3175		

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S3175	Continued From page 6 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 census equaled 6 residents. The sample included 3 residents and 2 closed record review residents. Based on record review and interview for one Resident (R) 136, the Operator failed to ensure a licensed nurse performed an assessment annually for residents who self-administered their medications. Findings included: - The "Resident Roster" obtained on 08/02/22 identified one resident who self-administered all her medications. Review of R136's "Medical Record" revealed she admitted to the facility on 04/20/22 with diagnoses of osteoporosis, glaucoma and fibromyalgia. R136's record lacked a current "Functional	S3175		

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S3175	Continued From page 7 Capacity Screen." R136's current "Negotiated Service Agreement" dated 04/29/22 identified R136 was able to self-administer her medications. R136's record lacked a current "Resident Care Plan." R136's current August 2022 "Medication Administration Record" (MAR) identified all medications as "self-administer medications." Review of R136's record on 08/02/22 lacked evidence a licensed nurse performed a self-administration of medication assessment. Interview on 08/02/22 at 04:00 PM with R136 stated she self-administered all her medications and stored them in her room. Interview on 08/02/22 at 05:09 PM, Operator/Licensed Nurse (LN) A and LN B confirmed they were unable to locate a medication self- administration assessment for R136. The facility failed to provide a policy for assessing any resident who chooses to self-administer medications. The facility failed to ensure a licensed nurse performed an assessment annually for R136, who self-administered all her medications.	S3175		
S3215 SS=F	26-41-205 (h) Medication Storage (h) Storage. Licensed nurses and medication	S3215		

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S3215	Continued From page 8 aides shall ensure that all medications and biologicals are securely and properly stored in 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)	S3215		

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S3215	Continued From page 9 The census equaled 6 residents. The sample included 3 residents and 2 closed record review residents. Based on observation, interview and record review for all residents living in the facility and receiving medication services, Operator/Licensed Nurse (LN) A failed to ensure all non-controlled medications and biologicals managed by the facility were stored in a locked medication room, cart, or cabinet and further failed to ensure all controlled medications managed by the facility were stored in a separately locked compartment within a locked medication room, cart or cabinet, which had the ability to affect all residents. Findings included: - On 08/02/22, Operator/ LN A provided a "Resident Roster" which included 6 residents and noted 5 of the 6 residents had impaired cognitive abilities. Observation on 08/02/22 at 10:27 AM revealed an unlocked and unsupervised medication cart in the dining room, which was located near the entrance of the facility. All medication drawers of the cart were able to be opened. The unlocked medication cart revealed a prescription for Hydrocodone (narcotic for pain) with R500's name on it in the top drawer. The controlled medication was not in a separately locked compartment within the medication cart. Interview on 08/02/22 at 10:29 AM with Certified Nurse Aide (CNA) C stated no LN or Certified Medication Aide (CMA) currently in facility. States LN B had to leave and was unsure what time LN B left facility. CNA C stated hospice	S3215		

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S3215	Continued From page 10 services dropped off a medication while LN B was out of the facility. CNA C locked the medication cart by engaging the lock button on the outside of the medication cart. Interview on 08/02/22 at 10:44 AM with Operator/ LN A confirmed medication cart should be locked at all times. Operator/LN A confirmed medication cart was left unlocked by LN B when she left the facility, which is how hospice services was able to place the controlled medication for Resident (R) 500 inside the medication cart. Facility's "Medication Storage" policy dated 03/30/20 recorded, "All medications will be stored in a locked space. This could mean a room, a cart or a drawer and may be state mandated. Narcotic medication that the community is responsible to administer must be kept in a double-locked space. The storage space will be kept locked at all times when not in use. Access to the medication storage space will be limited, each shift, to the person responsible for administering medication and his/her supervisor." Operator/LN A failed to ensure all non-controlled medications and biologicals managed by the facility were stored in a locked medication room, cart, or cabinet and further failed to ensure all controlled medications managed by the facility were stored in a separately locked compartment within a locked medication room, cart or cabinet, which had the ability to affect all residents.	S3215		
S3216 SS=D	26-41-205 (i) Disposition of Medication (i) Accountability and disposition of medications.	S3216		

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S3216	Continued From page 11 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 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: K.A.R. 26-41 205 (i) (1) (A) (B) The facility reported a census of 6 residents. The sampled included 3 residents and 2 closed record review residents. Based on interview and record review, Operator/Licensed Nurse (LN) A failed to maintain records documenting the destruction of any discontinued controlled medications and biologicals according to acceptable standards of practice by two licensed nurses or a licensed nurse and a licensed	S3216		

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S3216	Continued From page 12	S3216		

pharmacist when three controlled medications for 1 Resident (R) 912 were discontinued.

Findings included:

- On 08/02/22 at 10:43 AM, Operator/Licensed Nurse A provided the "Resident Roster" and a list of four discharged residents in the last six months. R912 was included on the discharge residents list. R912 discharged to funeral home on 07/13/22.

- Review of R912's "Medical Record" revealed she admitted to the facility on 12/28/17 with diagnoses of spinal stenosis, congestive heart failure, chronic pain and renal failure.

R912's "Functional Capacity Screen" dated 09/12/20 recorded the resident was unable to manager her medications and treatments.

R912's "Negotiated Service Agreement" dated 09/12/21 recorded the facility staff would manage the resident's medications.

Signed physician order dated 07/12/22 recorded, "Morphine Concentrate (narcotic for pain) 100 milligrams (mg)/ 5 milliliters (ml) (20 mg/ml) oral solution, 0.5 to 1.0 ml every 1-2 hours as needed for pain/restlessness or air hunger."

Review of facility's "controlled drug administration record" for R912 recorded Morphine Sulfate Solution 0.5 to 1.0 ml by mouth every 1-2 hours as needed for pain/restlessness/air hunger, quantity 30 ml. The record lacked signatures of two licensed nurses or a licensed nurse and a licensed pharmacist in

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S3216	Continued From page 13	S3216		

the "disposition of unused portion" on the "controlled drug administration record." A total of 26.5 ml of Morphine Sulfate Solution remained.

Signed physician order dated 07/01/22 recorded, "Hydrocodone (narcotic for pain) 5 milligrams (mg)- Acetaminophen 325 mg tablet, 1 tablet orally daily and every 4 hours as needed.

Review of facility's "controlled drug administration record" for R912 recorded Hydrocodone/Acetaminophen 5/325 mg by mouth daily, quantity 20. The bottom of the record recorded, "sent back to pharmacy 07/13/22." The record lacked signatures of two licensed nurses or a licensed nurse and a licensed pharmacist in the "Disposition of unused portion" on the "controlled drug administration record." A total of 9 tablets of Hydrocodone/Acetaminophen 5/325 mg remained.

Review of facility's "controlled drug administration record" for R912 recorded Hydrocodone/Acetaminophen 5/325 mg by mouth every four hours as needed for pain, quantity 20. The bottom of the record recorded, "sent back to pharmacy 07/13/22." The record lacked signatures of two licensed nurses or a licensed nurse and a licensed pharmacist in the "Disposition of unused portion" on the "controlled drug administration record." A total of 20 tablets of Hydrocodone/Acetaminophen 5/325 mg remained.

Interview on 08/03/22 at 12:10 PM with Operator/LN A confirmed records lacked signatures of two licensed nurses or a licensed

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S3216	Continued From page 14 nurse and a licensed pharmacist for the three discontinued controlled medications for R 912 and further confirmed facility staff were to sign in the "Disposition of unused portion" of the "controlled drug administration record." Facility's medication destruction/disposal policy requested on 08/02/22 at 05:27 PM. On 08/02/22 at 05:35 PM, Operator/LN A stated facility does not currently have a policy on medication destruction/disposal. Operator/Licensed Nurse A failed to maintain records documenting the destruction of any discontinued controlled medications and biologicals according to acceptable standards of practice by two licensed nurses or a licensed nurse and a licensed pharmacist when three controlled medications for one Resident (R) 912 were discontinued.	S3216		
S3280 SS=E	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		

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	N021006	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARTEN COUNTRYSIDE HOME INC	2454 HWY 15 NORTH ABILENE, KS 67410

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S3280	Continued From page 15 drill shall include evacuation of the residents to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-42-104 (d) (3) The census equaled 6 residents. The sample included 3 residents, 2 closed record review residents and review of 5 employee records. Based on record review and interview, Operator/Licensed Nurse (LN) A failed to ensure disaster and emergency preparedness by ensuring the performance of quarterly review of the facility's entire "Emergency Management Plan" with residents and staff. Findings included: - Review of the facility's "Emergency Management Plan" revealed the plan contained procedures to manage potential emergencies and disasters including fire, flood, severe weather, tornado, explosion, natural gas leak, lack of electrical, or water service, and missing residents. The facility failed to provide documentation regarding emergency management plan reviews with staff and residents for the first and second quarter of 2022. Interview on 08/02/22 with Operator/LN A confirmed no reviews were completed with residents and staff for the first and second	S3280		

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S3280	Continued From page 16 quarter of 2022. Facility's "Disaster and Emergency Preparedness" policy dated 01/20/14 recorded, "Staff: orientation, quarterly review, and annual in-service on the emergency management plan ...Residents ... have quarterly reviews documented that the emergency management plan is reviewed with residents." Operator/LN A failed to ensure disaster and emergency preparedness by the failure to ensure the performance of quarterly reviews of the facility's entire emergency plan with residents and staff.	S3280		
S3298 SS=E	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.	S3298		

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S3298	Continued From page 17 This REQUIREMENT is not met as evidenced by: KAR 26-41-206 (e) The census equaled 6 residents. Based on record review, observation, and interview for all residents living in the facility and receiving meal services, Operator/Licensed Nurse (LN) A failed to ensure the facility staff served food at the proper temperature. Findings included: - During the initial tour on 08/02/22, facility food temperature monitoring logs were requested, and the facility provided logs for "July 2022" and "August 2022." Record lacked breakfast and lunch food temperatures for the following dates: 07/11/22, 07/12/22, 07/13/22, 07/15/22, 07/16/22, 07/18/22, 07/20/22, 07/22/22, 07/28/22, 07/29/22, 07/30/22 and 07/31/22. Record lacked supper food temperatures for the following dates: 07/11/22, 07/12/22, 07/13/22, 07/15/22, 07/16/22, 07/18/22, 07/20/22, 07/22/22, 07/25/22, 07/26/22, 07/28/22, 07/29/22, 07/30/22 and 07/31/22. On 08/02/22 at 10:51 AM, Operator/LN A confirmed the facility was missing daily food temperature monitoring logs for July 2022. Observation on 08/02/22 at 12:15 PM revealed CNA C and CNA D served the lunchtime meal to	S3298		

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S3298	Continued From page 18 all residents living in the facility. Kansas Department of Agriculture Food Safety guidelines records hot food must be maintained at a temperature of 135 degrees Fahrenheit or above, cold foods at 41 degrees Fahrenheit or below. Operator/LN A provided a document (no title) (no date) which recorded, "Ensuring foods reach this safe minimum internal temperature with a food thermometer is the only reliable way to ensure safety and to determine the doneness of cooked meats, poultry, egg dishes and leftovers." Operator/LN A confirmed the document was the facility policy for food temperatures. For all residents of the facility, Operator/LN A failed to ensure facility staff served food at the proper temperature.	S3298		
S3310 SS=E	26-41-207 (b) (5-6) (c) Infection Control Policies (b) (5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; and (c) Each administrator or operator shall ensure the facility ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105	S3310		

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S3310	Continued From page 19	S3310		

This REQUIREMENT is not met as evidenced by:
K.A.R 26-41-207 (c)

The census totaled 6 residents. The sample included 3 residents, 2 closed record review residents and review of 5 newly hired employees. Based on record review and interview for 1 Resident (R) 136 and 4 staff (Certified Medication Aide (CMA) E, Certified Nurse Aide (CNA) D, CNA F and CNA G), the facility failed to ensure compliance with the State Agency's tuberculosis (TB) guidelines.

Findings included:

- Review of R136's "Medical Record" revealed she admitted to the facility on 04/20/22 and the record lacked evidence of completion of TB testing upon admission. Record further lacked evidence of completion of a TB questionnaire upon admission.

Review of CMA E's employee record revealed they hired onto the facility on 04/17/22. CMA E's record lacked evidence of completion of TB testing upon hire. Record further lacked evidence of completion of a TB questionnaire upon hire.

Review of CNA D's employee record revealed they hired onto the facility on 01/18/22. CNA D's record lacked evidence of TB testing and a TB questionnaire upon hire. CNA D's TB test was completed 03/12/22 and TB questionnaire was

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S3310	Continued From page 20	S3310		

completed on 03/29/22, approximately 2 months after being hired by the facility.

Review of CNA F's employee record revealed they hired onto the facility on 03/08/22. CNA F's record lacked evidence of TB testing and a TB questionnaire upon hire. CNA F's TB test and TB questionnaire were completed on 04/08/22, approximately 1 month after being hired by the facility.

Review of CNA G's employee record revealed they hired onto the facility on 06/24/22. CNA G's record lacked evidence of completion of TB testing and a TB questionnaire upon hire. CNA G's TB test and TB questionnaire were completed on 07/13/22, approximately 3 weeks after being hired by the facility.

Interview on 08/03/22 at 08:41 AM with Operator/ Licensed Nurse (LN) A confirmed records lacked a TB test or TB questionnaire for R136.

Interview on 08/02/22 at 4:47 PM with Operator/ LN A confirmed CMA E did not receive TB testing or a TB questionnaire upon hire and further confirmed CNA D, CNA F and CNA G's TB testing and TB questionnaires were not completed upon hire and were late.

The facility's "Policies and Procedures" dated 02/27/14 recorded, "Within 7 days of admission a TB skin test will be given (1 or 2 step, whichever is applicable.)" Policy failed to address staff and TB questionnaires.

The facility failed to ensure compliance with the State Agency's tuberculosis guidelines for adult

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S3310	Continued From page 21 care homes adopted by reference in K.A.R. 26-39-105, which had the potential to affect all residents.	S3310		