STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N028005	A. BUILDING: _____ B. WING _____	12/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RANCH HOUSE	2900 CAMPUS DRIVE GARDEN CITY, KS 67846

(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 certification Health Survey and complaint investigation #KS0013518.	S 000		
S9999	Final Observations KSA-39-926 License required to operate home The facility had 25 residents with 10 residents sampled for review. Based on interview and record review, the facility moved residents in to the facility prior to obtaining a license to operate. (#101, 102, 103, 104, 105, 106, 107, 108, 109, and 110) Findings included: - Review of clinical records of 10 sampled residents (#101, 102, 103, 104, 105, 106, 107, 108, 109, 110) revealed the residents moved in to the facility on 10/15/18. Per e-mail on 12/11/18 from Kansas Department for Aging and Disability Services Licensure Certification and Enforcement Manager, the facility relocated the residents of the former facility to the new building. The new building was initially licensed on 9/28/18 for 45 Assisted Living beds. The nursing facility portion of the building was not approved for licensure until 11/21/18. (The facility operated without a license from 10/15/18 -11/21/18 with 25 residents in the building.) Interview with administrative staff A on 11/27/18 at 5:15 p.m. confirmed the 25 residents moved in to the building prior to obtaining their license as directed from their corporate office.	S9999		

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
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S9999	Continued From page 1 The facility failed to obtain a license to operate prior to moving 25 residents in to the facility.	S9999		