STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N028003	A. BUILDING: _____ B. WING _____	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD OF GARDEN CITY	2414 N HENDERSON DR 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 the licensure resurvey for the above named facility conducted on 04/21/25, 04/22/25, and 04/23/25.	S 000		
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: K.A.R. 26-41-205 (g) (3) The facility reported a census of 27 residents. Based on observation and interview the Operator failed to ensure a licensed Pharmacist, or a "Licensed Nurse" (LN) placed the full name of the resident on the bottles of "Over the Counter" (OTC) medications. Findings included:	S3211		

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
	N028003	A. BUILDING: _____ B. WING _____	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD OF GARDEN CITY	2414 N HENDERSON DR 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
S3211	Continued From page 1 - Observation on 04/21/25 at approximately 02:35 PM, CMA A unlocked the medication cart labeled "Big Bertha". In the third drawer down on the left side of the cart were the following unlabeled OTC medications: 1 bottle of Geri Lanta 1 bottle of Equate Aspirin 325 "milligrams" (mg) Observation on 04/21/25 at approximately 02:35 PM of the fourth drawer down on the right-hand side of the medication cart labeled "Big Bertha" were the following unlabeled OTC medications: 1 bottle of Maalox 2 bottles of Senna 1 bottle of Magnesium Oxide 400 2 bottles of Pepcid 20mg Interview on 04/21/25 at approximately 02:40 PM with LN B and CMA A confirmed the bottles of OTC's lacked the full name of the resident. Review of the "Electronic Mail" (e-mail) dated 04/23/25 from Regional Nurse C revealed the following "Medication policy (OTC, Storage) is followed based on regulation requirements ...". The Operator failed to ensure a licensed Pharmacist, or a LN placed the full name of the resident on the bottles of OTC medications.	S3211		
S3215 SS=E	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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N028003	A. BUILDING: _____ B. WING _____	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD OF GARDEN CITY	2414 N HENDERSON DR 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
S3215	Continued From page 2 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: K.S.A. 26-41-205 (h) (1) The facility reported a census of 27 residents.	S3215		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N028003	A. BUILDING: _____ B. WING _____	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD OF GARDEN CITY	2414 N HENDERSON DR 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
S3215	Continued From page 3 The sample included 3 "Residents'" (R)'s 1, 2, and 3. Based on observation, interview, and record review the operator failed to ensure that all resident medications were 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 for R2 and R3. Findings included: - Record review for R2 revealed an admission date of 09/01/23 with diagnoses of depression, Alzheimer's Disease with late onset, dementia in other diseases classified elsewhere with unspecified severity with other behavioral disturbances, acquired absence of the left leg below the knee, chronic obstructive pulmonary disease, and essential hypertension. Review of R2's combined "Functional Capacity Screen (FCS)/Negotiated Service Agreement (NSA)/Health Service Plan (HSP)" dated 01/02/25 revealed, R2 required physical assistance with bathing, dressing, toileting, transferring and management of his medications and medical treatments. Under the section titled "Management of Mediations", staff was identified as "Responsible" for the medication service provided to R2. Under the section titled "Medications/Treatments" "Medication Management" it was identified that the "Nurse prepares and administers all medications per physician orders". The "Focus" section titled "Medications" revealed the following; R2 would continue to have medications administered by facility staff. "Nursing will delegate medication	S3215		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N028003	A. BUILDING: _____ B. WING _____	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD OF GARDEN CITY	2414 N HENDERSON DR 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
S3215	Continued From page 4	S3215		

administration to facility staff that is certified/licensed to administer medications. Staff to order, prepare, and give medications to residents and monitor for side effects and report to the "Resident Care Coordinator" (RCC) when needed".

Observation on 04/23/25 at approximately 11:00 AM of R2's bathroom cabinet, revealed the following "Over the Counter" (OTC) medications:

1 tube of Ny Stop
1 tube of Mupirocin Ointment
2 tubes of Equate Athlete foot cream
1 tube of Selan Silver skin protectant cream

Interview on 04/23/25 at approximately 11:00 AM with Operator D confirmed the facility managed and administered R2's medications and medical treatments.

- Record review for R3 revealed an admission date of 11/20/19 with diagnoses of chronic atrial fibrillation, essential hypertension, alcohol abuse uncomplicated, traumatic subdural hemorrhage without loss of consciousness, insomnia, unspecified cirrhosis of the liver, and obsessive-compulsive disorder.

Review of R3's combined FCS/NSA/HSP dated 09/05/24 revealed R3 required supervision with bathing and toileting. R3 was independent with dressing transferring, walking, and eating. R3 required physical assistance with managing his medications and medical treatments. Under the section titled "Management of Medications", staff was identified as "Responsible" for the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N028003	A. BUILDING: _____ B. WING _____	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD OF GARDEN CITY	2414 N HENDERSON DR 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
S3215	Continued From page 5 medication service provided to R2. Under the section titled "Medications/Treatments" "Medication Management" it was identified that the "Nurse prepares and administers all medications per physician orders". Observation on 04/23/25 at approximately 11:15 AM of R3's bathroom cabinet revealed the following OTC medications: 1 bottle of Guardian Alkums antiacid 3 boxes of Cepacol Sore Throat Lozenges 1 bag of Good Sense cough drops 2 tubes of Sheffield Muscle Rub Cream 2 tubes of Muscle Pain Reliver Cream 1 box of Thera Care Pain Patches Interview on 04/23/25 at approximately 11:15 AM with Operator D confirmed the facility managed and administered R3's medications and medical treatments. The operator failed to ensure that all resident medications were 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 for R2 and R3.	S3215		
S3290 SS=D	26-41-206 (a) (b) Dietary Services (a) Provision of dietary services. The administrator or operator of each assisted living facility or residential health care facility shall ensure the provision or coordination of dietary services to residents as identified in each resident ' s negotiated service agreement. If the	S3290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N028003	A. BUILDING: _____ B. WING _____	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD OF GARDEN CITY	2414 N HENDERSON DR 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
S3290	Continued From page 6 administrator or operator of the facility establishes a contract with another entity to provide or coordinate the provision of dietary services to the residents, the administrator or operator shall ensure that entity ' s compliance with these regulations. (b) Staff. The supervisory responsibility for dietetic services shall be assigned to one employee. (1) A dietetic services supervisor or licensed dietician shall provide scheduled on-site supervision in each facility with 11 or more residents. (2) If a resident ' s negotiated service agreement includes the provision of a therapeutic diet, mechanically altered diet, or thickened consistency of liquids, a medical care provider ' s order shall be on file in the resident ' s clinical record, and the diet or liquids, or both, shall be prepared according to instructions from a medical care provider or licensed dietitian. This REQUIREMENT is not met as evidenced by: K.S.A. 26-41-206 (b) (2) The facility reported a census of 27 residents. The sample included 3 "Residents'" (R)'s 1, 2, and 3. Based on interview, and record review the Operator failed to ensure the facility had an order from the provider for R2's liquids to be prepared to a thickened consistency. The Operator further failed to ensure the thickened consistency liquids for R2 were prepared according to instructions from a medical care provider or a licensed	S3290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N028003	A. BUILDING: _____ B. WING _____	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD OF GARDEN CITY	2414 N HENDERSON DR 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
S3290	Continued From page 7 dietitian. Findings included: - Record review for R2 revealed an admission date of 09/01/23 with diagnoses of depression, Alzheimer's Disease with late onset, dementia in other diseases classified elsewhere with unspecified severity with other behavioral disturbances, acquired absence of the left leg below the knee, chronic obstructive pulmonary disease, and essential hypertension. Review of R2's combined "Functional Capacity Screen (FCS)/Negotiated Service Agreement (NSA)/Health Service Plan (HSP)" dated 01/02/25 revealed, R2 required physical assistance with bathing, dressing, toileting, transferring and management of his medications and medical treatments. Under the section titled "Eating" it was marked that R2 was independent with eating, and there was a check mark next to "Thickened Liquids". Record review of R2's "Electronic Medical Record" (eMAR) under the "Miscellaneous" tab was a document titled "Order Summary Report" dated 01/03/25 and signed by the medical provider. The document lacked an order for thickened liquids. Record review of R2's "e-Mar" under the "Progress Notes" tab were the following entries; On 02/27/25 at 06:25 PM a nurse note revealed R2 choked while eating. "He finally un-lodged	S3290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N028003	A. BUILDING: _____ B. WING _____	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD OF GARDEN CITY	2414 N HENDERSON DR 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
S3290	Continued From page 8 and vomited". R2 was sent to the local hospital by ambulance for evaluation. On 03/21/25 at 01:49 PM a nurse note revealed R2 "Struggles to feed himself at times". Assistance provided as needed. Interview on 04/23/25 at approximately 01:00 PM with Dietary Manager I confirmed she did not have instructions from the provider or the licensed dietitian on how to prepare the thickened liquids for R2. Interview on 04/23/25 at approximately 01:30 PM with Regional Nurse J confirmed there was not an order for the thickened liquids for R2, and the thickened liquids were a "nursing intervention". The Operator failed to ensure the facility had an order from the provider for R2's liquids to be prepared to a thickened consistency. The Operator further failed to ensure the thickened consistency liquids for R2 were prepared according to instructions from a medical care provider or a licensed dietitian.	S3290		
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	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N028003	A. BUILDING: _____ B. WING _____	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD OF GARDEN CITY	2414 N HENDERSON DR 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
S3310	Continued From page 9 (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.S.A. 26-41-207 (c) The facility reported a census of 27 residents. The sample included 3 "Residents'" (R)'s 1, 2, and 3 and 5 newly hired employees. Based on observation, interview, and record review the operator failed to ensure the facility's compliance with the department's "Tuberculosis" (TB) guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 for newly hired "Certified Medication Aides'" (CMA)'s E and F, and newly hired"Certified Nurse Aides" (CNA)'s G and H. Findings included: - Review of CMA Es' personnel file revealed she began employment on 10/17/23. CMA E's personnel record lacked documentation of the required two step TB test being administered within seven days of employment. Review of CMA F's personnel file revealed she began employment on 04/10/24. CMA F's personnel record lacked documentation of the required two step TB test being administered	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N028003	A. BUILDING: _____ B. WING _____	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD OF GARDEN CITY	2414 N HENDERSON DR 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
S3310	Continued From page 10 within seven days of employment. Review of CNA G's personnel file revealed she began her employment on 07/23/24. CNA G's personnel record lacked documentation of the required two step TB test being administered within seven days of employment. Review of CNA H's personnel file revealed she began her employment on 12/09/23. CNA H's personnel record lacked documentation of the required two step TB test being administered within seven days of employment. Review of the "electronic mail" (e-mail) from Regional Nurse C revealed the following; The community followed the Kansas Tuberculosis guidelines for compliance in the "Assisted Living" (AL) setting. When audits were completed, they found missing TB test for staff and residents. Chest x-rays and the QuantiFERON lab test were completed to be in compliance. Review of the "Tuberculosis (TB) Guidelines for Adult Care Homes" dated June 2013 revealed the following: "Each new resident and new employee shall receive a two-step TST or an IGRA for Mycobacterium tuberculosis within 7 days of residency or employment ..." The operator failed to ensure the facility's compliance with the department's TB guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 for newly hired CMA's E and F, and newly hired CNA's G and H.	S3310		
S9999	Final Observations	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N028003	A. BUILDING: _____ B. WING _____	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD OF GARDEN CITY	2414 N HENDERSON DR 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
S9999	Continued From page 11 Kansas Statute 39-981. Authorized electronic monitoring; reasonable accommodations; notice; consent; use as evidence; prohibitions. (d) A resident, or such resident's guardian or legal representative, who wishes to conduct authorized electronic monitoring shall notify the adult care home on a form prescribed by the secretary for aging and disability services. (i) Each adult care home shall post a conspicuous notice at the entrance to the adult care home and each resident's room stating that the rooms of some residents may be monitored electronically by or on behalf of the room's resident or residents. This Requirement is not met as evidenced by: Scope and Severity of E. The facility reported a census of 27. Based on observation and interviews, for all residents the facility failed to post a conspicuous notice at the entrance to the adult care home and each resident's room stating that the rooms of some residents may be monitored electronically by or on behalf of the room's resident or residents. Findings included: - Observation on 04/21/25 at approximately 01:50 PM of the front door of the facility, a small black and gold sticker measuring approximately 2 inches by 3 inches, that stated "SECURITY	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N028003	A. BUILDING: _____ B. WING _____	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD OF GARDEN CITY	2414 N HENDERSON DR 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
S9999	Continued From page 12 NOTICE", "This property is Protected by Video Surveillance". Observation on 04/21/25 at approximately 02:00 PM during the facility tour with Operator D, a small gold sticker measuring approximately 2 inches by 3 inches, that stated "SECURITY NOTICE", "This property is Protected by Video Surveillance" was on one resident room door. Interview on 04/21/25 at approximately 03:00 PM with Operator D confirmed there were five residents who had electronic monitoring equipment in their rooms. Operator D continued to state that two of the residents had monitors the families could not remote in on. Operator D stated that these were "baby monitors", and the receivers were kept at the employee workstation for monitoring as interventions for the residents. Operator D stated that there were three other residents who had electronic monitoring devices in their rooms that the families could remote in on. Operator D further confirmed that only one resident room had a notice of being monitored. Operator D confirmed the notice stating "the rooms of some residents may be monitored electronically by or on behalf of the room's resident or residents" was not posted at the entrance to the facility, and the notice was not posted on each resident room door. The facility failed to post a conspicuous notice at the entrance to the adult care home and each resident's room stating that the rooms of some residents may be monitored electronically by or on behalf of the room's resident or residents.	S9999		