Kansas Department on Aging

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | N044007 | A. BUILDING: _____ B. WING _____ | R 07/10/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| F W HUSTON MEDICAL CENTER - JEFFERSON SUITE | 408 DELAWARE STREET WINCHESTER, KS 66097 |

| (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<br><br>An offsite revisit survey was conducted on 07/10/2023 for all previous deficiencies cited on 06/15/2023. All deficiencies have been corrected as of the compliance date of 07/07/2023, and no new noncompliance was found. The facility is in compliance with all regulations surveyed. | {S 000} | | |

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