Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VALHLTHCLOSE	A. BUILDING: _____ B. WING _____	R 07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	400 12TH STREET VALLEY FALLS, KS 66088

(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 An offsite revisit survey was conducted on 07/31/24 for all previous deficiencies cited on 07/22/24. All deficiencies have been corrected as of the compliance date of 07/24/24, 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