

Kansas Department on Aging

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|-----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                         |                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>N023018</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>03/01/2018</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>VINTAGE PARK AT BALDWIN CITY LLC</b> |                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>321 CRIMSON AVENUE<br/>BALDWIN, KS 66006</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                    | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                   | ID<br>PREFIX<br>TAG                                                                      | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| S 000                                                                       | <p>INITIAL COMMENTS</p> <p>A re-survey for licensure conducted at the above<br/>named facility on 2/28/18 and 3/1/18 resulted in a<br/>finding of no deficiency citations.</p> | S 000                                                                                    |                                                                                                                          |                                                        |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE