

Kansas Department on Aging

|                                                               |                                                                                                                                   |                                                                                           |                                                                                                                          |                                                        |
|---------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION           |                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>N087053</b>               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/31/2016</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CLEARWATER VILLAGE</b> |                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>440 N 4TH STREET<br/>CLEARWATER, KS 67026</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>The resurvey at the above named facility on 8-31-16 revealed a finding of no deficiency citations.</p> | S 000                                                                                     |                                                                                                                          |                                                        |

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

TITLE

(X6) DATE