

Kansas Department on Aging

|                                                                      |                                                                                                                                                                                        |                                                                                              |                                                                                                                          |                                                        |
|----------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                  |                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>N023021</b>                  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/16/2020</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>NEUVANT HOUSE OF LAWRENCE</b> |                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1216 B BILTMORE DRIVE<br/>LAWRENCE, KS 66049</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 special infection control survey for COVID-19 for the above named facility conducted on 07/16/2020 resulted in findings of no deficiency citations.</p> | S 000                                                                                        |                                                                                                                          |                                                        |

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

TITLE

(X6) DATE