

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>N046108</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 02/20/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>SHAWNEE HILLS SENIOR LIVING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>6335 MAURER ROAD SHAWNEE, KS 66217</b>
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(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}	<p><b>INITIAL COMMENTS</b></p> <p>An offsite revisit survey was conducted on 02/20/25 for all previous deficiencies cited on 01/29/25. All deficiencies have been corrected as of the compliance date of 02/20/25, and no new noncompliance was found. The facility is in compliance with all regulations surveyed.</p>	{S 000}		

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

TITLE

(X6) DATE