STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
B089091 Y1	A. Building B. Wing Y2	9/12/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
KARAWAY, LLC	1815 SW WESTWOOD CIRCLE TOPEKA, KS 66604

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S5026	Correction	ID Prefix S5105	Correction	ID Prefix S5192	Correction
Reg. # 26-42-101 (f) (1)	Completed	Reg. # 26-42-202 (a)	Completed	Reg. # 26-42-206 (e)	Completed
LSC	09/12/2023	LSC	09/12/2023	LSC	09/12/2023
ID Prefix S5230	Correction	ID Prefix S5258	Correction	ID Prefix S5286	Correction
Reg. # 26-42-207 (b)(5)(6) (c)	Completed	Reg. # 26-42-102 (d)	Completed	Reg. # 26-42-205 (b)	Completed
LSC	09/12/2023	LSC	09/12/2023	LSC	09/12/2023
ID Prefix S5313	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 26-42-205 (g) (3)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	09/12/2023	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
8/23/2023	☐ YES ☐ NO