STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
39081 Y1	A. Building B. Wing Y2	7/15/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLEY PLACE #1	618 SW OAKLEY AVENUE TOPEKA, KS 66606

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 S5095	Correction	ID Prefix S5105	Correction
Reg. # 26-42-101 (f) (1)	Completed	Reg. # 26-42-201 (d)	Completed	Reg. # 26-42-202 (a)	Completed
LSC	07/15/2024	LSC	07/15/2024	LSC	07/15/2024
ID Prefix S5171	Correction	ID Prefix S5230	Correction	ID Prefix	Correction
Reg. # 26-42-204 (i)	Completed	Reg. # 26-42-207 (b)(5)(6) (c)	Completed	Reg. #	Completed
LSC	07/15/2024	LSC	07/15/2024	LSC	
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	
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 Christopher Peppel, RN	DATE 7/18/24
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE Nurse Surveyor	DATE 7/18/2024

FOLLOWUP TO SURVEY COMPLETED ON
6/24/2024

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

EVENT ID: 02RH12

STATE FORM: REVISIT REPORT (11/06)