STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
N087083 Y1	A. Building B. Wing Y2	10/16/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CREDO MEMORY CARE OF WICHITA	6887 E ROCKHILL STREET WICHITA, KS 67206

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 S3026	Correction	ID Prefix S3085	Correction	ID Prefix S3090	Correction
Reg. # 26-41-101 (f) (1)	Completed	Reg. # 26-41-202 (a)	Completed	Reg. # 26-41-202 (c)	Completed
LSC	10/16/2025	LSC	10/16/2025	LSC	10/16/2025
ID Prefix S3211	Correction	ID Prefix S3215	Correction	ID Prefix S3261	Correction
Reg. # 26-41-205 (g) (3)	Completed	Reg. # 26-41-205 (h)	Completed	Reg. # 26-41-105 (f) (11)	Completed
LSC	10/16/2025	LSC	10/16/2025	LSC	10/16/2025
ID Prefix S3299	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 26-41-206 (e) (1)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	10/16/2025	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	
9/22/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO