

**STATE FORM: REVISIT REPORT**

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER N023025	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 4/15/2025
NAME OF FACILITY CEDARHURST OF LAWRENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 4450 BAUER FARM DRIVE LAWRENCE, KS 66049

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 S3082	Correction	ID Prefix S3085	Correction
Reg. # 26-41-101 (f) (1)	Completed	Reg. # 26-41-201 (d)	Completed	Reg. # 26-41-202 (a)	Completed
LSC	04/15/2025	LSC	04/15/2025	LSC	04/15/2025
ID Prefix S3155	Correction	ID Prefix S3200	Correction	ID Prefix S3261	Correction
Reg. # 26-41-204 (a)	Completed	Reg. # 26-41-205 (d) (1-2)	Completed	Reg. # 26-41-105 (f) (11)	Completed
LSC	04/15/2025	LSC	04/15/2025	LSC	04/15/2025
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	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 3/20/2025		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		