

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number N089045	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 10/1/2015
Name of Facility LEGEND AT CAPITAL RIDGE	Street Address, City, State, Zip Code 1931 SW ARVONIA PLACE TOPEKA, KS 66615	

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>S3085</u>	Correction Completed 10/01/2015	ID Prefix <u>S3101</u>	Correction Completed 10/01/2015	ID Prefix <u>S3298</u>	Correction Completed 10/01/2015
Reg. # <u>26-41-202 (a)</u>		Reg. # <u>26-41-202 (h)</u>		Reg. # <u>26-41-206 (d)</u>	
LSC _____		LSC _____		LSC _____	
ID Prefix <u>S3299</u>	Correction Completed 10/01/2015	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # <u>26-41-206 (e) (1)</u>		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	

Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____
State Agency _____				
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____
CMS RO _____				

Followup to Survey Completed on:
 9/9/2015

_____ Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**