Department of Health and Human Services
Centers For Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
535021	A. Building **01 - MAIN BUILDING 01** B. Wing	08/05/2005

Name of Facility	Street Address, City, State, Zip Code
WYOMING RETIREMENT CENTER	890 HWY 20 SOUTH BASIN, WY 82410

This report is completed by a qualified State surveyor for the Medicare Medicaid and/or Clinical Laboratory Improvement Amendments program to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction 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 CMS2567 (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	Correction Completed **06/01/2005**	ID Prefix	Correction Completed **06/01/2005**	ID Prefix	Correction Completed **06/01/2005**
Reg. # **NFPA 101** LSC **K0018**		Reg. # **NFPA 101** LSC **K0027**		Reg. # **NFPA 101** LSC **K0029**	
ID Prefix	Correction Completed **08/05/2005**	ID Prefix	Correction Completed **06/01/2005**	ID Prefix	Correction Completed
Reg. # **NFPA 101** LSC **K0050**		Reg. # **NFPA 101** LSC **K0130**		Reg. # LSC	
ID Prefix FSES	Correction Completed	ID Prefix FSES	Correction Completed	ID Prefix FSES	Correction Completed
Reg. # LSC K0012		Reg. # LSC K0017		Reg. # LSC K0056	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:		Date:
					8/5/05
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**		

Followup to Survey Completed on
06/01/2005

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