

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 535025	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 3/10/2005
Name of Facility CHEYENNE HEALTH CARE		Street Address, City, State, Zip Code 2700 E-12TH STREET CHEYENNE, WY 82001

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 CMS-2567 (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 F0276 Reg. # 483.20(b)(5) LSC _____	Correction Completed 2/19/2005	ID Prefix F0313 Reg. # 483.25(b) LSC _____	Correction Completed 2/19/2005	ID Prefix F0314 Reg. # 483.25(e) LSC _____	Correction Completed 2/19/2005
ID Prefix F0316 Reg. # 483.25(d)(2) LSC _____	Correction Completed 2/19/2005	ID Prefix F0329 Reg. # 483.25(d)(1) LSC _____	Correction Completed 2/19/2005	ID Prefix F0465 Reg. # 483.70(h) LSC _____	Correction Completed 2/19/2005
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor: <i>Betty Nelson</i>	Date:
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor: <i>Betty Nelson Health Surveyor</i>	Date: 3/10/05

Followup to Survey Completed on:
1/6/2005

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