

Post-Certification Revisit Report

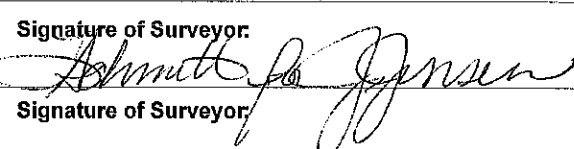
Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this 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<br>53A043 | (Y2) Multiple Construction<br>A. Building 01 - MAIN BUILDING 01<br>B. Wing | (Y3) Date of Revisit<br>11/28/2005 |
|-------------------------------------------------------------------|----------------------------------------------------------------------------|------------------------------------|

|                                                         |                                                                                 |
|---------------------------------------------------------|---------------------------------------------------------------------------------|
| Name of Facility<br>PLATTE COUNTY MEMORIAL NURSING HOME | Street Address, City, State, Zip Code<br>204 15TH STREET<br>WHEATLAND, WY 82201 |
|---------------------------------------------------------|---------------------------------------------------------------------------------|

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 _____<br>Reg. # NFPA 101<br>LSC K0027 | Correction Completed<br>10/28/2005 | ID Prefix _____<br>Reg. # NFPA 101<br>LSC K0029 | Correction Completed<br>10/28/2005 | ID Prefix _____<br>Reg. # NFPA 101<br>LSC K0056 | Correction Completed<br>12/15/2005 |
| ID Prefix _____<br>Reg. # _____<br>LSC _____    | Correction Completed               | ID Prefix _____<br>Reg. # _____<br>LSC _____    | Correction Completed               | ID Prefix _____<br>Reg. # _____<br>LSC _____    | Correction Completed               |
| ID Prefix _____<br>Reg. # _____<br>LSC _____    | Correction Completed               | ID Prefix _____<br>Reg. # _____<br>LSC _____    | Correction Completed               | ID Prefix _____<br>Reg. # _____<br>LSC _____    | Correction Completed               |
| ID Prefix _____<br>Reg. # _____<br>LSC _____    | Correction Completed               | ID Prefix _____<br>Reg. # _____<br>LSC _____    | Correction Completed               | ID Prefix _____<br>Reg. # _____<br>LSC _____    | Correction Completed               |
| ID Prefix _____<br>Reg. # _____<br>LSC _____    | Correction Completed               | ID Prefix _____<br>Reg. # _____<br>LSC _____    | Correction Completed               | ID Prefix _____<br>Reg. # _____<br>LSC _____    | Correction Completed               |

|                                   |                                                                                                 |                |                                                                                                             |                |
|-----------------------------------|-------------------------------------------------------------------------------------------------|----------------|-------------------------------------------------------------------------------------------------------------|----------------|
| Reviewed By _____<br>State Agency | Reviewed By  | Date: 12/15/05 | Signature of Surveyor:  | Date: 12/15/05 |
| Reviewed By _____<br>CMS RO       | Reviewed By _____                                                                               | Date: _____    | Signature of Surveyor: _____                                                                                | Date: _____    |

Followup to Survey Completed on:  
10/7/2005

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