DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER/SUPPLIER/CLIA/IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
53A049 Y1	A. Building OLOF01 B. Wing Y2	4-20-06 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOSHEN CARE CENTER	2009 LARAMIE, TORRINGTON, WY

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix _____ Reg. # _____ LSC K-018	Correction Completed WAIVER	ID Prefix _____ Reg. # _____ LSC K-011	Correction Completed 4/13/06	ID Prefix _____ Reg. # _____ LSC K027	Correction Completed 4/13/06
ID Prefix _____ Reg. # _____ LSC K-029	Correction Completed 4/13/06	ID Prefix _____ Reg. # _____ LSC K-067	Correction Completed 4/13/06	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed __/__/__
ID Prefix _____ Reg. # _____ LSC K-130	Correction Completed 4/13/06	ID Prefix _____ Reg. # _____ LSC K-154	Correction Completed 4/13/06	ID Prefix _____ Reg. # _____ LSC K-155	Correction Completed 4/13/06
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 (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
			[signature]	4-21-06
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE STAFF ENGINEER OFFICE OF HEALTHCARE LICENSING & SURVEYS	

FOLLOWUP TO SURVEY COMPLETED ON

☐ CHECK ( ) FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

Form CMS-2567B (9-92)

Input into ACO4 faxed to 4/21/06 TS

CMS REGIONAL OFFICE