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
535033 Y1	A. Building _____ B. Wing _____ Y2	4/20/07 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
Castle Rock Convalescent Center	1445 Uinta, Green River WY 82935

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).

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F	Correction	ID Prefix F	Correction	ID Prefix F	Correction
Reg. # 164	Completed	Reg. # 170	Completed	Reg. # 272	Completed
LSC	4/9/07	LSC	4/9/07	LSC	4/9/07
ID Prefix F	Correction	ID Prefix F	Correction	ID Prefix F	Correction
Reg. # 281	Completed	Reg. # 282	Completed	Reg. # 315	Completed
LSC	4/9/07	LSC	4/9/07	LSC	4/9/07
ID Prefix F	Correction	ID Prefix F	Correction	ID Prefix F	Correction
Reg. # 323	Completed	Reg. # 334	Completed	Reg. # 371	Completed
LSC	4/9/07	LSC	4/9/07	LSC	4/9/07
ID Prefix F	Correction	ID Prefix F	Correction	ID Prefix F	Correction
Reg. # 444	Completed	Reg. # 492	Completed	Reg. # 507	Completed
LSC	4/9/07	LSC	4/9/07	LSC	4/9/07
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC	__/__/__	LSC	__/__/__	LSC	__/__/__

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TB	DATE 4/25/07	SIGNATURE OF SURVEYOR Jean McCue	DATE 4/20/07
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE RD - health surveyor	

FOLLOWUP TO SURVEY COMPLETED ON 2/23/07

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

Form CMS-2567B (9-92)

V

CMS REGIONAL OFFICE