

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 535034	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 01/30/2006
Name of Facility WESTWARD HEIGHTS CARE CENTER		Street Address, City, State, Zip Code 150 CARING WAY LANDER, WY 82520

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).

94118

Upload by Julie 1-31-06

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
Correction Completed		Correction Completed		Correction Completed	
ID Prefix <u>F0279</u>	<u>01/02/2006</u>	ID Prefix <u>F0318</u>	<u>01/02/2006</u>	ID Prefix <u>F0324</u>	<u>01/02/2006</u>
Reg. # <u>483.20(d), 483.20(k)(1)</u>		Reg. # <u>483.25(e)(2)</u>		Reg. # <u>483.25(h)(2)</u>	
LSC _____		LSC _____		LSC _____	
Correction Completed		Correction Completed		Correction Completed	
ID Prefix <u>F0331</u>	<u>01/02/2006</u>	ID Prefix _____		ID Prefix _____	
Reg. # <u>483.25(l)(2)(ii)</u>		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	
Correction Completed		Correction Completed		Correction Completed	
ID Prefix _____		ID Prefix _____		ID Prefix _____	
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	
Correction Completed		Correction Completed		Correction Completed	
ID Prefix _____		ID Prefix _____		ID Prefix _____	
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	
Correction Completed		Correction Completed		Correction Completed	
ID Prefix _____		ID Prefix _____		ID Prefix _____	
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	
Reviewed By _____	Reviewed By <u>[Signature]</u>	Date: _____	Signature of Surveyor: <u>[Signature]</u>	Date: <u>1/30/06</u>	
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____		
CMS RO					
Followup to Survey Completed on: _____		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO			