State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
ALF026	A. Building B. Wing	07/08/2015

Name of Facility	Street Address, City, State, Zip Code
DEER TRAIL ASSISTED LIVING	2360 REAGAN AVENUE ROCK SPRINGS, WY 82901

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (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 S5095 Reg. # Ch 12 Sec 8 (a)(i) LSC	Correction Completed 07/08/2015	ID Prefix S5101 Reg. # Ch 12 Sec 8 (a)(vii) LSC	Correction Completed 07/08/2015	ID Prefix S5104 Reg. # Ch 12 Sec 8 (a)(x) LSC	Correction Completed 07/08/2015
ID Prefix S5136 Reg. # Ch 12 Sec 10 (f)(ii) LSC	Correction Completed 07/08/2015	ID Prefix S5137 Reg. # Ch 12 Sec 10 (f)(iii) LSC	Correction Completed 07/08/2015	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	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	TS 7/16/15		[signature]	7/16/15
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	

Followup to Survey Completed on:
03/26/2015

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