

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number 535030	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 06/05/2015
Name of Facility NEW HORIZONS CARE CENTER		Street Address, City, State, Zip Code 1111 LANE 12 LOVELL, WY 82431

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 <u>S7036</u> Reg. # <u>IPC</u> LSC _____	Correction Completed 06/05/2015	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
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Reviewed By State Agency	Reviewed By <u>6/22/15 TS</u>	Date:	Signature of Surveyor: <u>[Signature]</u> 34354	Date: <u>6/05/15</u>
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	

Followup to Survey Completed on: 04/07/2015	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
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