State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
ALF026	A. Building B. Wing	7/8/2015

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 Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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Reviewed By State Agency	Reviewed By TB 7/24/15	Date:	Signature of Surveyor: Janelle Conlin RS	Date:	
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:	
Followup to Survey Completed on: 11/26/2014		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?		YES	NO