

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 535048	(Y2) Multiple Construction A. Building 01 - MAIN BUILDING 01 B. Wing	(Y3) Date of Revisit 10/12/2015
Name of Facility WORLAND HEALTHCARE AND REHABILITATION CENTI		Street Address, City, State, Zip Code 1901 HOWELL AVENUE WORLAND, WY 82401

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
Correction Completed ID Prefix _____ Reg. # NFPA 101 LSC K0018	10/05/2015	Correction Completed ID Prefix _____ Reg. # NFPA 101 LSC K0029	10/05/2015	Correction Completed ID Prefix _____ Reg. # NFPA 101 LSC K0046	10/05/2015
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 _____	
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Correction Completed ID Prefix _____ Reg. # _____ LSC _____		Correction Completed ID Prefix _____ Reg. # _____ LSC _____		Correction Completed ID Prefix _____ Reg. # _____ LSC _____	
Reviewed By _____ State Agency	Reviewed By <i>BS</i> Date: 12/21/15	Signature of Surveyor: <i>[Signature]</i> 34354	Date: 10/13/15		
Reviewed By _____ CMS RO	Reviewed By _____ Date: _____	Signature of Surveyor: _____			
Followup to Survey Completed on: 08/18/2015		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO			