

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 535049	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 6/2/2016
NAME OF FACILITY LIFE CARE CENTER OF CASPER	STREET ADDRESS, CITY, STATE, ZIP CODE 4041 SOUTH POPLAR STREET CASPER, WY 82601	

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0167	Correction	ID Prefix F0225	Correction	ID Prefix F0253	Correction
Reg. # 483.10(g)(1)	Completed	Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - (4)	Completed	Reg. # 483.15(h)(2)	Completed
LSC	04/20/2016	LSC	04/26/2016	LSC	05/20/2016
ID Prefix F0281	Correction	ID Prefix F0311	Correction	ID Prefix F0431	Correction
Reg. # 483.20(k)(3)(i)	Completed	Reg. # 483.25(a)(2)	Completed	Reg. # 483.60(b), (d), (e)	Completed
LSC	04/28/2016	LSC	04/28/2016	LSC	04/28/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) <i>TS 6/1/16</i>	DATE	SIGNATURE OF SURVEYOR <i>[Signature]</i>	DATE 6/2/16
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 4/7/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
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