DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
535036 Y1	A. Building B. Wing Y2	8/25/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
RAWLINS REHABILITATION AND WELLNESS	542 16TH STREET RAWLINS, WY 82301

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 F0155	Correction	ID Prefix F0156	Correction	ID Prefix F0280	Correction
Reg. # 483.10(b)(4)	Completed	Reg. # 483.10(b)(5) - (10), 483.10(b)(1)	Completed	Reg. # 483.20(d)(3), 483.10(k)(2)	Completed
LSC	08/05/2016	LSC	08/05/2016	LSC	08/05/2016
ID Prefix F0314	Correction	ID Prefix F0328	Correction	ID Prefix F0329	Correction
Reg. # 483.25(c)	Completed	Reg. # 483.25(k)	Completed	Reg. # 483.25(l)	Completed
LSC	08/05/2016	LSC	08/05/2016	LSC	08/05/2016
ID Prefix F0332	Correction	ID Prefix F0441	Correction	ID Prefix	Correction
Reg. # 483.25(m)(1)	Completed	Reg. # 483.65	Completed	Reg. #	Completed
LSC	08/05/2016	LSC	08/05/2016	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) TS 8/29/16	DATE 8/25/16	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO