

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 535045	Y1	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01 B. Wing	Y2	DATE OF REVISIT 9/1/2016	Y3
NAME OF FACILITY POWELL VALLEY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 777 AVENUE H POWELL, WY 82435		

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 _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # NFPA 101 _____	Completed	Reg. # NFPA 101 _____	Completed	Reg. # NFPA 101 _____	Completed
LSC K0038 _____	08/26/2016	LSC K0056 _____	08/26/2016	LSC K0064 _____	08/26/2016
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # NFPA 101 _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC K0147 _____	08/26/2016	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 _____	
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 9/1/16</i>	DATE <i>9/1/16</i>	SIGNATURE OF SURVEYOR <i>[Signature]</i>	DATE <i>9/1/2016</i>	
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE	
FOLLOWUP TO SURVEY COMPLETED ON 6/30/2016			☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO		