

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 535056	Y1	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING B. Wing	Y2	DATE OF REVISIT 9/12/2016	Y3
NAME OF FACILITY SAGE VIEW CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1325 SAGE STREET ROCK SPRINGS, WY 82901		

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 K0017	08/10/2016	LSC K0018	08/10/2016	LSC K0029	08/10/2016
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0034	08/10/2016	LSC K0038	08/10/2016	LSC K0047	08/10/2016
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0050	08/10/2016	LSC K0051	08/10/2016	LSC K0062	08/10/2016
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0064	08/10/2016	LSC K0106	08/10/2016	LSC K0144	08/10/2016
ID Prefix _____	Correction	ID Prefix <u>Waived</u>	Correction	ID Prefix _____	Correction
Reg. # NFPA 101	Completed	Reg. # <u>NFPA 101</u>	Completed	Reg. # _____	Completed
LSC K0147	08/10/2016	LSC <u>K0056</u>		LSC _____	
REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) <u>RS</u>	DATE <u>9/17/16</u>	SIGNATURE OF SURVEYOR <u>[Signature]</u>		DATE <u>9/12/2016</u>
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE		DATE
FOLLOWUP TO SURVEY COMPLETED ON 7/20/2016			☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO		