

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 535031	Y1	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01 B. Wing	Y2	DATE OF REVISIT 1/20/2017	Y3
NAME OF FACILITY WIND RIVER REHABILITATION AND WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 1002 FOREST DRIVE RIVERTON, WY 82501		

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 WAIVER	Reg. # NFPA 101	Completed WAIVER
LSC K0222	12/02/2016	LSC K0227	12/19/2016	LSC K0321	12/19/2016
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed WAIVER	Reg. # NFPA 101	Completed
LSC K0342	01/01/2017	LSC K0351	12/19/2016	LSC K0353	12/02/2016
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # _____	Completed
LSC K0511	12/02/2016	LSC K0920	12/02/2016	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) AS	DATE 1/23/17	SIGNATURE OF SURVEYOR	DATE 1-23-17
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON
11/2/2016

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