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

POST-CERTIFICATION REVISIT REPORT

PROVIDER/SUPPLIER/CLIA/IDENTIFICATION NUMBER Y1	MULTIPLE CONSTRUCTION A. Building ___________________ B. Wing ___________________ Y2	DATE OF REVISIT Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE

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 _____________ Reg. # ______________ LSC _____________	Correction Completed ____/____/____	ID Prefix _____________ Reg. # ______________ LSC _____________	Correction Completed ____/____/____	ID Prefix _____________ Reg. # ______________ LSC _____________	Correction Completed ____/____/____
ID Prefix _____________ Reg. # ______________ LSC _____________	Correction Completed ____/____/____	ID Prefix _____________ Reg. # ______________ LSC _____________	Correction Completed ____/____/____	ID Prefix _____________ Reg. # ______________ LSC _____________	Correction Completed ____/____/____
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ID Prefix _____________ Reg. # ______________ LSC _____________	Correction Completed ____/____/____	ID Prefix _____________ Reg. # ______________ LSC _____________	Correction Completed ____/____/____	ID Prefix _____________ Reg. # ______________ LSC _____________	Correction Completed ____/____/____
ID Prefix _____________ Reg. # ______________ LSC _____________	Correction Completed ____/____/____	ID Prefix _____________ Reg. # ______________ LSC _____________	Correction Completed ____/____/____	ID Prefix _____________ Reg. # ______________ LSC _____________	Correction Completed ____/____/____

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	
FOLLOWUP TO SURVEY COMPLETED ON		☐ CHECK (√) FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO		