

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number N008004	(Y2) Multiple Construction A. Building _____ B. Wing _____	(Y3) Date of Revisit 8/8/2014
Name of Facility FOUNTAINVIEW NURSING & REHAB CENTER		Street Address, City, State, Zip Code 601 N ROSE HILL RD ROSE HILL, KS 67133

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>S3080</u>	Correction Completed <u>08/08/2014</u>	ID Prefix <u>S3090</u>	Correction Completed <u>08/08/2014</u>	ID Prefix <u>S3145</u>	Correction Completed <u>08/08/2014</u>
Reg. # <u>26-41-201 (a) (b)</u>	LSC _____	Reg. # <u>26-41-202 (c)</u>	LSC _____	Reg. # <u>26-41-203 (e)</u>	LSC _____
ID Prefix <u>S3171</u>	Correction Completed <u>08/08/2014</u>	ID Prefix <u>S3175</u>	Correction Completed <u>08/08/2014</u>	ID Prefix <u>S3248</u>	Correction Completed <u>08/08/2014</u>
Reg. # <u>26-41-204 (i)</u>	LSC _____	Reg. # <u>26-41-205 (a) (1)</u>	LSC _____	Reg. # <u>26-41-102 (d)</u>	LSC _____
ID Prefix <u>S3299</u>	Correction Completed <u>08/08/2014</u>	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # <u>26-41-206 (e) (1)</u>	LSC _____	Reg. # _____	LSC _____	Reg. # _____	LSC _____
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____	LSC _____	Reg. # _____	LSC _____	Reg. # _____	LSC _____
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____	LSC _____	Reg. # _____	LSC _____	Reg. # _____	LSC _____

Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____
State Agency _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____
CMS RO _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: 7/21/2014	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? <table style="display: inline-table; vertical-align: middle;"> <tr> <td style="padding: 0 10px;">YES</td> <td style="padding: 0 10px;">NO</td> </tr> </table>	YES	NO
YES	NO		