

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 175501	(Y2) Multiple Construction A. Building _____ B. Wing _____	(Y3) Date of Revisit 10/14/2014
Name of Facility FAMILY HEALTH & REHABILITATION CENTER	Street Address, City, State, Zip Code 639 S MAIZE COURT WICHITA, KS 67209	

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0224	Correction Completed 09/29/2014	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # 483.13(c)	_____	Reg. # _____	_____	Reg. # _____	_____
LSC _____	_____	LSC _____	_____	LSC _____	_____
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____	_____	Reg. # _____	_____	Reg. # _____	_____
LSC _____	_____	LSC _____	_____	LSC _____	_____
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____	_____	Reg. # _____	_____	Reg. # _____	_____
LSC _____	_____	LSC _____	_____	LSC _____	_____
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____	_____	Reg. # _____	_____	Reg. # _____	_____
LSC _____	_____	LSC _____	_____	LSC _____	_____

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

Followup to Survey Completed on: 9/11/2014	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?
	YES NO