

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number TN1702	(Y2) Multiple Construction A. Building 01 - MAIN BUILDING 01 B. Wing	(Y3) Date of Revisit 9/29/2010
Name of Facility ALAMO NURSING AND REHABILITATION CENTER	Street Address, City, State, Zip Code 580 W MAIN STREET ALAMO, TN 38001	

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>N0832</u> Reg. # <u>1200-8-6-.08(2)</u> LSC _____	Correction Completed 09/13/2010	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

Reviewed By <u>✓</u>	Reviewed By <u>TOP</u>	Date: <u>9/29/10</u>	Signature of Surveyor: <u>J.P. HALL</u>	Date: <u>9/29/10</u>
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____
Followup to Survey Completed on: 9/13/2010		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2587) Sent to the Facility?		
		YES NO		