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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
535050 Y1	A. Building B. Wing Y2	1/29/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR CARE CENTER	4 NORTH FORK ROAD FORT WASHAKIE, WY 82514

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 F0176	Correction	ID Prefix F0253	Correction	ID Prefix F0272	Correction
Reg. # 483.10(n)	Completed	Reg. # 483.15(h)(2)	Completed	Reg. # 483.20(b)(1)	Completed
LSC	12/01/2015	LSC	12/31/2015	LSC	12/01/2015
ID Prefix F0279	Correction	ID Prefix F0280	Correction	ID Prefix F0282	Correction
Reg. # 483.20(d), 483.20(k)(1)	Completed	Reg. # 483.20(d)(3), 483.10(k)(2)	Completed	Reg. # 483.20(k)(3)(ii)	Completed
LSC	12/01/2015	LSC	12/01/2015	LSC	12/01/2015
ID Prefix F0318	Correction	ID Prefix F0323	Correction	ID Prefix F0329	Correction
Reg. # 483.25(e)(2)	Completed	Reg. # 483.25(h)	Completed	Reg. # 483.25(l)	Completed
LSC	01/01/2016	LSC	12/01/2015	LSC	12/15/2015
ID Prefix F0371	Correction	ID Prefix F0431	Correction	ID Prefix F0441	Correction
Reg. # 483.35(i)	Completed	Reg. # 483.60(b), (d), (e)	Completed	Reg. # 483.65	Completed
LSC	12/20/2015	LSC	12/15/2015	LSC	12/20/2015
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)	DATE	SIGNATURE OF SURVEYOR	DATE
	TB 2/10/16		[signature]	2/5/16
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 11/5/15

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