

## POST-CERTIFICATION REVISIT REPORT

|                                                              |    |                                                                       |                                                                               |                              |    |
|--------------------------------------------------------------|----|-----------------------------------------------------------------------|-------------------------------------------------------------------------------|------------------------------|----|
| PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER<br>53A050 | Y1 | MULTIPLE CONSTRUCTION<br>A. Building 01 - MAIN BUILDING 01<br>B. Wing | Y2                                                                            | DATE OF REVISIT<br>4/18/2016 | Y3 |
| NAME OF FACILITY<br>STAR VALLEY CARE CENTER                  |    |                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br>110 HOSPITAL LANE<br>AFTON, WY 83110 |                              |    |

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<br>Y4      | DATE<br>Y5 | ITEM<br>Y4      | DATE<br>Y5 | ITEM<br>Y4      | DATE<br>Y5 |
|-----------------|------------|-----------------|------------|-----------------|------------|
| ID Prefix _____ | Correction | ID Prefix _____ | Correction | ID Prefix _____ | Correction |
| Reg. # NFPA 101 | Completed  | Reg. # _____    | Completed  | Reg. # _____    | Completed  |
| LSC K0144       | 04/08/2016 | LSC _____       |            | LSC _____       |            |
| ID Prefix _____ | Correction | ID Prefix _____ | Correction | ID Prefix _____ | Correction |
| Reg. # _____    | Completed  | Reg. # _____    | Completed  | Reg. # _____    | Completed  |
| LSC _____       |            | LSC _____       |            | LSC _____       |            |
| ID Prefix _____ | Correction | ID Prefix _____ | Correction | ID Prefix _____ | Correction |
| Reg. # _____    | Completed  | Reg. # _____    | Completed  | Reg. # _____    | Completed  |
| LSC _____       |            | LSC _____       |            | LSC _____       |            |
| ID Prefix _____ | Correction | ID Prefix _____ | Correction | ID Prefix _____ | Correction |
| Reg. # _____    | Completed  | Reg. # _____    | Completed  | Reg. # _____    | Completed  |
| LSC _____       |            | LSC _____       |            | LSC _____       |            |
| ID Prefix _____ | Correction | ID Prefix _____ | Correction | ID Prefix _____ | Correction |
| Reg. # _____    | Completed  | Reg. # _____    | Completed  | Reg. # _____    | Completed  |
| LSC _____       |            | LSC _____       |            | LSC _____       |            |
| ID Prefix _____ | Correction | ID Prefix _____ | Correction | ID Prefix _____ | Correction |
| Reg. # _____    | Completed  | Reg. # _____    | Completed  | Reg. # _____    | Completed  |
| LSC _____       |            | LSC _____       |            | LSC _____       |            |

|                                                      |                                     |                 |                           |                 |
|------------------------------------------------------|-------------------------------------|-----------------|---------------------------|-----------------|
| REVIEWED BY<br>STATE AGENCY <input type="checkbox"/> | REVIEWED BY<br>(INITIALS) <i>TS</i> | DATE<br>4/12/16 | SIGNATURE OF SURVEYOR<br> | DATE<br>4/20/16 |
| REVIEWED BY<br>CMS RO <input type="checkbox"/>       | REVIEWED BY<br>(INITIALS)           | DATE            | TITLE                     | DATE            |

|                                             |                                                                                                                                             |                                                          |
|---------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|
| FOLLOWUP TO SURVEY COMPLETED ON<br>3/8/2016 | <input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
|---------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|