

8/10/2011

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number WY0039	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 8/4/2011
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Name of Facility STAR VALLEY CARE CENTER	Street Address, City, State, Zip Code 110 HOSPITAL LANE AFTON, WY 83110
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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>SNH</u> Reg. # _____ LSC _____	Correction Completed 07/08/2011	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
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 _____ State Agency	Reviewed By <u>TS 4/10/11</u> Date: <u>8/10/11</u>	Signature of Surveyor: <u>[Signature]</u> Date: <u>8/10/11</u>
Reviewed By _____ CMS RO	Reviewed By _____ Date: _____	Signature of Surveyor: _____ Date: _____

Followup to Survey Completed on:

5/26/2011

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?

YES NO