

Healthcare Licensing and Surveys

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>WY0017</b>                    | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/12/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>MORNING STAR CARE CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4 NORTH FORK ROAD<br/>FORT WASHAKIE, WY 82514</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| S 000                                                               | <p><b>OPENING COMMENTS</b></p> <p>Rules and Regulations utilized for this survey are:</p> <p>Rules and Regulations for Program<br/>Administration of Nursing Care Facilities, Chapter<br/>11, effective 07/01/2020</p> <p>Rules and Regulations for Licensure of Nursing<br/>Care Facilities, Chapter 19, effective 06/26/2000<br/>A licensure survey was conducted by Healthcare<br/>Licensing and Surveys from 1/9/23 to 1/12/23.<br/>Based upon the findings of the survey team, it<br/>was determined the facility was in compliance<br/>with State requirements.</p> | S 000                                                                                         |                                                                                                                          |                                                        |

Wyoming Dept of Health, Aging Division, Healthcare Licensing and Surveys  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

02/01/23