

WDH - Office of Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: WY0033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/17/2009
NAME OF PROVIDER OR SUPPLIER WEST PARK LONG TERM CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 707 SHERIDAN AVENUE CODY, WY 82414		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
SNH	LIC REGS FOR NURSING HOMES This State Rules and Regulations is not met as evidenced by: A survey was conducted by the Office of Healthcare Licensing and Surveys on 12/14/09 through 12/17/09. Based upon the findings of the survey team, it was determined that this facility was in compliance with the state requirements.	SNH		

Wyoming Dept of Health, Office of Healthcare Licensing and Surveys

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6809

F64M11

If continuation sheet 1 of 1