

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: WY0029	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/01/2012
NAME OF PROVIDER OR SUPPLIER SOUTH CENTRAL WYO HEALTHCARE & REH/			STREET ADDRESS, CITY, STATE, ZIP CODE 542 16TH STREET RAWLINS, WY 82301		
(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 On March 1, 2012, a State Licensure Survey was conducted for South Central Wyoming Healthcare & Rehabilitation Center located in Rawlins, Wyoming. It was determined, based upon the findings of the survey team, that no deficiencies were identified pertaining to State Licensure requirements	SNH			

Wyoming Dept of Health, Aging Division, Healthcare Licensing and Surveys

TITLE

(X6) DATE

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

STATE FORM

6899

FZZK11

If continuation sheet 1 of 1