

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: WY0004	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/30/2012
NAME OF PROVIDER OR SUPPLIER CASTLE ROCK CONVALESCENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1445 UINTA DRIVE GREEN RIVER, WY 82935		
(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 A survey was conducted by the Office of Healthcare licensing and Surveys on 8/27/12 to 8/30/12. Based upon the findings of the survey team, it was determined this facility was in compliance with the state 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

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If continuation sheet 1 of 1