

WDH - Office of Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: WY0002	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/15/2009
NAME OF PROVIDER OR SUPPLIER BONNIE BLUEJACKET MEMORIAL NURSING I			STREET ADDRESS, CITY, STATE, ZIP CODE 388 SOUTH US HWY 20 BASIN, WY 82410		
(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: Licensure Survey: A survey was conducted by the Office of Healthcare Licensing and Surveys on 10/12/09 through 10/15/09. 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