

WDH - Office of 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>WY0024</b>        | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                                                         | (X3) DATE SURVEY<br>COMPLETED<br><br><b>11/05/2009</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>POWELL VALLEY CARE CENTER</b> |                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>777 AVENUE H<br/>POWELL, WY 82435</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                               |
| SNH                                                                  | <p>LIC REGS FOR NURSING HOMES</p> <p>This State Rules and Regulations is not met as evidenced by:<br/>A survey was conducted by the Office of Healthcare Licensing and Surveys on 11/2/09 through 11/5/09. Based upon the findings of the survey team, it was determined that this facility was in compliance with the state requirements.</p> | SNH                                                                               |                                                                                                                          |                                                        |

Wyoming Dept of Health, Office of Healthcare Licensing and Surveys

TITLE

(X6) DATE

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