

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: WY0018	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/26/2011
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABII			STREET ADDRESS, CITY, STATE, ZIP CODE 3128 BOXELDER DRIVE CHEYENNE, WY 82001		
(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 Licensure Survey: A survey was conducted by the Office of Healthcare Licensing and Surveys on 5/23/11 through 5/26/11. 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, Aging Division, Healthcare Licensing and Surveys

TITLE

(X6) DATE

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

STATE FORM

6809

CDNS11

If continuation sheet 1 of 1