

Wyoming Dept of Health - Office of Healthcare Licensi

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: WY0039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/06/2009
NAME OF PROVIDER OR SUPPLIER STAR VALLEY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 615 AFTON, WY 83110		
(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	
S 000	State Rules and Regulations It was determined, based upon the findings of the surveyor from the Office of Healthcare Licensing and Surveys, that no deficiencies were identified pertaining to the state licensure survey. Therefore, as of the date the survey was completed, your facility is presumed to be in substantial compliance with the participation requirements for State Licensure Rules and Regulations	S 000			

Wyoming Dept of Health, Office of Healthcare Licensing and Surveys

TITLE

(X6) DATE

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

STATE FORM

5509

SPWJ11

If continuation sheet 1 of 1