

Wyoming Dept of Health - Office of Healthcare Licensi

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 02/20/2009
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
S 000	State Rules and Regulations A survey was conducted by the Office of Healthcare Licensing and Surveys on 2/17/09 through 2/20/09. Based upon the findings of the survey team, it was determined that this facility was in compliance with the state requirements.	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

6899

8V8611

If continuation sheet 1 of 1