

WDH - Office of Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: WY0038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/27/2009
NAME OF PROVIDER OR SUPPLIER WYOMING RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 890 US HWY 20 SOUTH 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	--- DO NOT USE THIS TAG # --- STATE REGULATIONS On 8/24/09 through 8/27/09 a re-certification survey was conducted at Wyoming Retirement Center in Basin, Wyoming. It was determined, based upon the findings of the survey team, that no deficiencies were identified pertaining to the state 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

6899

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If continuation sheet 1 of 1