

WDH - Office of Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: WY0005	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/28/2010
NAME OF PROVIDER OR SUPPLIER CHEYENNE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2700 E 12TH STREET 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 This State Rules and Regulations is not met as evidenced by: A State Licensure survey was conducted at the Cheyenne Health Care Center located in Cheyenne, WY on from 1/25/10 to 1/28/10. It was determined, based upon the findings of the survey team, that no deficiencies were identified pertaining to State Licensure requirements.	SNH			

Wyoming Dept of Health, Office of Healthcare Licensing and Surveys

TITLE

(X6) DATE

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

STATE FORM

0899

28JW11

If continuation sheet 1 of 1