Wyoming Dept of Health - Office of Healthcare Licensii

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY0018	A. BUILDING _____ B. WING _____	03/27/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN TOWERS HEALTHCARE	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
S 000	State Rules and Regulations On 3/24/09 through 3/27/09 a re-certification survey was conducted at Mountain Towers Rehabilitation and Care Center in Cheyenne, Wyoming. It was determined, based upon the findings of the survey team, that no deficiens were identified pertaining to the state rules and regulations.	S 000	POC ACCEPTED W/ DAD SHACKS, NHA, DJ 4/24/09.	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 4/20109

STATE FORM 6899 UUN611 If continuation sheet 1 of 1

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