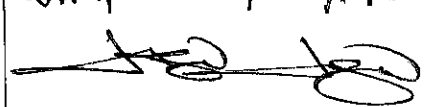


Wyoming Dept of Health - Office of Healthcare Licensi

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: WY0018	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/27/2009
NAME OF PROVIDER OR SUPPLIER MOUNTAIN TOWERS HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 deficiencies were identified pertaining to the state rules and regulations.	S 000	PC ACCEPTED W/ DAD SACKS, N/A, on 4/24/09. 	

Wyoming Dept of Health, Office of Healthcare Licensing and Surveys

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

STATE FORM

6899

UUN611

TITLE

(X6) DATE

Executive Director

4/20/09

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Licensing and Surveys

