

Healthcare Licensing and Surveys

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 08/01/2014
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABII		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	OPENING COMMENTS Rules and Regulations utilized for this survey are: Rules and Regulations for Program Administration of Nursing Care Facilities, Chapter 11, effective 06/26/2000 Rules and Regulations for Licensure of Nursing Care Facilities, Chapter 19, effective 06/26/2000 On 7/28/14 through 8/1/14 a re-certification survey was conducted at Kindred Transitional Care Center in Cheyenne, Wyoming. It was determined, based upon the findings of the survey team, the facility was in substantial compliance with the state requirements.	S 000		

Wyoming Dept of Health, Aging Division, Healthcare Licensing and Surveys

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

TITLE

STATE FORM

6890

HU2411

If continuation sheet 1 of 1

(X6) DATE
8/25/14