

Wyoming Dept of Health - Office of Healthcare Licensi

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: WY0033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/25/2008
NAME OF PROVIDER OR SUPPLIER WEST PARK LONG TERM CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 707 SHERIDAN AVENUE CODY, WY 82414		
(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 September 25, 2008 a State Licensure Survey was conducted for West Park Long Term Care Center located in Cody, Wyoming. It was determined, based upon the findings of the survey team, that no deficiencies were identified pertaining to State Licensure requirements	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

PJYG11

If continuation sheet 1 of 1