

WDH - Office of Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: WY0034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/24/2009
NAME OF PROVIDER OR SUPPLIER WESTON COUNTY HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1124 WASHINGTON BLVD NEWCASTLE, WY 82701		
(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: It was determined, based upon the findings of the surveyor from the Office of Healthcare Licensing and Surveys, that no deficiencies were identified pertaining to the state licensure survey. Therefore, as of the date the survey was completed, your facility is presumed to be in substantial compliance with the participation requirements for the State of Wyoming Rules and Regulations.	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

8899

VZY011

If continuation sheet 1 of 1