

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: WY0019	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/26/2016
NAME OF PROVIDER OR SUPPLIER NEW HORIZONS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1111 LANE 12 LOVELL, WY 82431		
(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 Licensure Survey: A survey was conducted by the Healthcare Licensing and Surveys on 5/23/16 through 5/26/16. Based upon the findings of the survey team, it was determined that this facility was in 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

(X6) DATE