

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: WY0004	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/09/2011
NAME OF PROVIDER OR SUPPLIER CASTLE ROCK CONVALESCENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1445 UINTA DRIVE GREEN RIVER, WY 82935		
(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 On 6/6/11 through 6/9/11 a re-certification survey was conducted at Castle Rock Convalescent Center in Green River, Wyoming. It was determined, based upon the findings of the survey team, that the facility was in compliance with State 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

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If continuation sheet 1 of 1