

Healthcare Licensing and Surveys

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 12/14/2017
NAME OF PROVIDER OR SUPPLIER MISSION AT CASTLE ROCK REHABILITATION			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	
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 A survey was conducted by Healthcare Licensing and Surveys on 12/11/17 through 12/14/17. Based upon the findings of the survey team, it was determined that this facility was in compliance with 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