

Wyoming Dept of Health - Office of Healthcare Licensi

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: WY0009	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/14/2009
NAME OF PROVIDER OR SUPPLIER CROOK COUNTY MEDICAL SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE BOX 517 SUNDANCE, WY 82729		
(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 It was determined, based upon the findings of the survey team from the Office of Healthcare Licensing and Surveys, that no deficiencies were identified pertaining to state licensure requirements. Therefore, as of the date the survey was completed, your facility is presumed to be in substantial compliance with the participation requirements of Wyoming State rules and regulations.	S 000			

Wyoming Dept of Health, Office of Healthcare Licensing and Surveys

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Neris Blum

TITLE

CEO/Administrator

(X6) DATE

6/05/2009

STATE FORM

6899

ZPPN11

Wyoming Dept of Health Continuation sheet 1 of 1

JUN 08 2009

Office of Healthcare
Licensing and Surveys