

Wyoming Dept of Health - Office of Healthcare Licensi

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 08/21/2008
NAME OF PROVIDER OR SUPPLIER NEW HORIZONS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1115 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	State Rules and Regulations On September 21, 2008 a State Licensure Survey was conducted for New Horizons Care Center located in Lovell, Wyoming. It was determined, based upon the findings of the survey team, that no deficiencies were identified pertaining to State Licensure requirements.	S 000			

Wyoming Dept of Health, Office of Healthcare Licensing and Surveys

TITLE

(X6) DATE

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

STATE FORM

6899

MSW211

If continuation sheet 1 of 1