

PRINTED: 03/28/2011
FORM APPROVED
OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER

LIFE CARE CENTER OF CASPER

STREET ADDRESS, CITY, STATE, ZIP CODE

4041 SOUTH POPLAR STREET

CASPER, WY 82601

(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)
COMPLETION
DATE

F 000

INITIAL COMMENTS

F 000

A survey was conducted by the Office of Healthcare Licensing and Surveys on 3/17/11. It was determined, based upon findings of the survey team, that no deficiencies were identified pertaining to the complaint investigation.

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.