

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ALF001	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/29/2012
NAME OF PROVIDER OR SUPPLIER VETERANS' HOME OF WYOMING		STREET ADDRESS, CITY, STATE, ZIP CODE 700 VETERANS' LANE BUFFALO, WY 82834		
(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
SALF	LIC REGS FOR ASSISTED LIVING FACILITIES On 11/28/12 through 11/29/12 a complaint investigation was conducted for the Veterans' Home located in Buffalo, Wyoming. It was determined, based upon the findings of the survey team, that no deficiencies were identified pertaining to the complaint investigation.	SALF		

Wyoming Dept of Health, Aging Division, Healthcare Licensing and Surveys

TITLE

(X6) DATE

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

STATE FORM

6899

WTOX11

If continuation sheet 1 of 1