

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ALF27	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/22/2013
NAME OF PROVIDER OR SUPPLIER MONDELL HEIGHTS RETIREMENT COMMUNIT			STREET ADDRESS, CITY, STATE, ZIP CODE 106 E MAIN STREET NEWCASTLE, WY 82701		
(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 5/21/13 a complaint investigation was conducted at the Mondell Heights Assisted Living Facility in Newcastle WY. It was determined based upon survey findings during the investigation, the allegation of Unqualified Personnel, staff improperly qualified was unsubstantiated		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

LUHS11

If continuation sheet 1 of 1