

WDH - Office of Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ALF010	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/07/2011
NAME OF PROVIDER OR SUPPLIER BEE HIVE HOMES OF EVANSTON			STREET ADDRESS, CITY, STATE, ZIP CODE 1949 WEST UINTA STREET EVANSTON, WY 82930		
(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 A complaint survey was conducted by the Office of Healthcare Licensing and Surveys on 4/6/11 through 4/7/11. 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, Office of Healthcare Licensing and Surveys

TITLE

(X6) DATE

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