

WDH - Office of Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ALF002	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2011
NAME OF PROVIDER OR SUPPLIER GARDEN SQUARE OF CASPER			STREET ADDRESS, CITY, STATE, ZIP CODE 1950 SOUTH BEVERLY 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) COMPLETE DATE	
SALF	LIC REGS FOR ASSISTED LIVING FACILITIES On 5/5/11 a complaint investigation was conducted for Garden Square of Casper located in Casper, Wyoming. It was determined, based upon the findings of the surveyor, 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

STATE FORM

6899

GOLQ11

If continuation sheet 1 of 1