

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ALF014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/10/2012
NAME OF PROVIDER OR SUPPLIER SPRING WIND ASSISTED LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 1072 NORTH 22ND STREET LARAMIE, WY 82072		
(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 08/10/12 a State Licensure Survey was conducted for Spring Wind Assisted Living Community, located in Laramie, Wyoming. It was determined, based upon the findings of the survey team, that no deficiencies were identified pertaining to State Licensure requirements.	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

6QVY11

If continuation sheet 1 of 1