

Healthcare Licensing and Surveys

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>WY0038             | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br>05/11/2017 |
| NAME OF PROVIDER OR SUPPLIER<br><br>WYOMING RETIREMENT CENTER |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>890 US HWY 20 SOUTH<br>BASIN, WY 82410 |                                                                                                                          |                                                 |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                        |
| S 000                                                         | <p>OPENING COMMENTS</p> <p>Rules and Regulations utilized for this survey are:</p> <p>Rules and Regulations for Program<br/>Administration of Nursing Care Facilities, Chapter<br/>11, effective 06/26/2000</p> <p>Rules and Regulations for Licensure of Nursing<br/>Care Facilities, Chapter 19, effective 06/26/2000<br/>A survey was conducted by Healthcare Licensing<br/>and Surveys on 5/8/17 through 5/11/17. Based<br/>upon the findings of the survey team, it was<br/>determined that this facility was in compliance<br/>with State requirements.</p> | S 000                                                                           |                                                                                                                          |                                                 |

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

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

TITLE

(X6) DATE

STATE FORM

6599

19MQ11

If continuation sheet 1 of 1