

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><b>ALF022</b>                  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R-C<br/>11/21/2017</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>AGAPE MANOR INC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>830 NORTH MAIN STREET<br/>BUFFALO, WY 82834</b> |                                                                                                                          |                                                                |
| (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 Assisted Living Facilities,<br/>Chapter 12, effective 12/12/2007</p> <p>Rules and Regulations for Licensure of Assisted<br/>Living Facilities, Chapter 4, effective 06/28/2001</p> <p>A revisit survey was conducted on 11/21/2017 for<br/>all previous deficiencies cited on 9/12/2017. All<br/>deficiencies have been corrected, and no new<br/>noncompliance was found. The facility is in<br/>compliance with all regulations surveyed.</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