

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ALF011	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 11/02/2018
NAME OF PROVIDER OR SUPPLIER TENDER HEART ASSISTED LIVING FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 624 TWIN RIDGE AVENUE 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
{S 000}	Opening Comments Rules and Regulations utilized for this survey are: Rules and Regulations for Program Administration of Assisted Living Facilities, Chapter 12, effective 12/12/2007 Rules and Regulations for Licensure of Assisted Living Facilities, Chapter 4, effective 06/28/2001 A revisit survey was conducted 10/8/18 to 11/2/18 for all previous deficiencies cited 7/19/18. All deficiencies except for S5074 have been corrected. S5074 has a completion date of 9/2/19.	{S 000}			

Wyoming Dept of Health, Aging Division, Healthcare Licensing and Surveys
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE