Healthcare Licensing and Surveys

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | WY9044 | A. BUILDING: _____ B. WING _____ | R 06/02/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COTTONWOOD CREEK OF CHEYENNE | 6800 FAITH DRIVE CHEYENNE, WY 82009 |

| (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<br><br>Rules and Regulations utilized for this survey are:<br><br>Rules and Regulations for Program Administration of Assisted Living Facilities, Chapter 12, effective 08/24/2020.<br><br>Rules and Regulations for Licensure of Assisted Living Facilities, Chapter 4, effective 06/28/2001. A revisit survey was conducted on 6/2/21 for the food service supervision deficiency cited on 3/2/21. The deficiency has been corrected, and no new noncompliance was found. The facility is in compliance with all regulations surveyed. | {S 000} | | |