

Healthcare Licensing and Surveys

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|---------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>WY0038                | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br>B. WING: _____                                                       |  | (X3) DATE SURVEY COMPLETED<br><br>R<br>07/15/2021 |
| 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 Administration of Nursing Care Facilities, Chapter 11, effective 07/01/2020</p> <p>Rules and Regulations for Licensure of Nursing Care Facilities, Chapter 19, effective 06/26/2000</p> <p>A revisit survey was conducted on 7/14/21 through 7/15/21 for all previous deficiencies cited on 5/6/21. All deficiencies have been corrected, and no new noncompliance was found. The facility is in 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

Electronically Signed

*[Signature]* NHA

TITLE

(X6) DATE

8-16-21

STATE FORM

5899

3Q9C12

If continuation sheet 1 of 1