

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

ALF020

(X2) MULTIPLE CONSTRUCTION

A. BUILDING: _____

B. WING: _____

(X3) DATE SURVEY
COMPLETED

R

06/08/2022

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LEGACY HOMES ASSISTED LIVING

2391 MUDDYSTRING RD 117
THAYNE, WY 83127(X4) ID
PREFIX
TAGSUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)ID
PREFIX
TAGPROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY)(X5)
COMPLETE
DATE

{S 000}

OPENING COMMENTS

{S 000}

Rules and Regulations utilized for this survey are:

Rules and Regulations for Program
Administration of Assisted Living Facilities,
Chapter 12, effective 08/24/2020.Rules and Regulations for Licensure of Assisted
Living Facilities, Chapter 4, effective 06/28/2001.
A revisit survey was conducted on 5/27/22
through 6/8/22 for all previous deficiencies cited
on 3/29/22. All deficiencies have been corrected,
and no new noncompliance was found. The
facility is in compliance with all regulations
surveyed.Wyoming Dept of Health, Aging Division, Healthcare Licensing and Surveys
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

E J Mill 6-27-22