

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ALF017	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 04/21/2023
NAME OF PROVIDER OR SUPPLIER HOMESTEAD ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 950 HOMESTEAD AVENUE RIVERTON, WY 82501		
(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 08/24/2020. Rules and Regulations for Licensure of Assisted Living Facilities, Chapter 4, effective 08/28/2001. A revisit survey was conducted from 4/19/23 to 4/21/23 for all previous deficiencies cited on 12/13/22. All deficiencies have been corrected, and no new noncompliance was found. The facility is in compliance with all regulations surveyed.	{S 000}		

FAXED
4/24/23
2:1505

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

TITLE

(X6) DATE

STATE FORM

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UWGO12

4.24.2023

If continuation sheet 1 of 1