

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ALF004	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/11/2025
NAME OF PROVIDER OR SUPPLIER PARK PLACE ASSISTED LIVING COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 1930 EAST 12 STREET CASPER, WY 82601		
(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 06/28/2001. A complaint survey by Healthcare Licensing and Surveys was conducted on 3/11/25 prompted by complaints LIC-25-031 and LIC-25-033. It was determined, based upon the findings of the survey team, that no deficiencies were identified pertinent to the complaint investigation.	S 000		

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

TITLE

(X6) DATE

STATE FORM

8899

ZX1K11

If continuation sheet 1 of 1