

PRINTED: 10/03/2024
FORM APPROVED

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ALF003	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 09/19/2024	
NAME OF PROVIDER OR SUPPLIER EDGEWOOD MEADOW WIND		STREET ADDRESS, CITY, STATE, ZIP CODE 3955 EAST 12TH STREET CASPER, WY 82609		
(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}	General Comments A Life Safety Code revisit survey was conducted by Healthcare Licensing and Surveys on 09/19/2024 for all previous deficiencies identified on 06/13/2024. All deficiencies have been corrected, and no new noncompliance was found. The facility is now in compliance.	{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

6899

H2B512

If continuation sheet 1 of 1