

Wyoming State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/14/2025	
NAME OF PROVIDER OR SUPPLIER Crook County Medical Services District Long Term Care				STREET ADDRESS, CITY, STATE, ZIP CODE 713 Oak St , Sundance, Wyoming, 82729			
(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) COMPLETION DATE	
S0000	OPENING COMMENTS Rules and Regulations utilized for this survey are: Rules and Regulations for Program Administration of Nursing Care Facilities, Chapter 11, effective 07/01/2020 Rules and Regulations for Licensure of Nursing Care Facilities, Chapter 19, effective 06/26/2000 A licensure survey was conducted by Healthcare Licensing and Surveys from 8/11/25 through 8/14/25. Based upon the findings of the survey team, it was determined the facility was in compliance with State requirements.		S0000			09/02/2025	

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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