Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	532002	A. BUILDING: _____ B. WING _____	07/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING STATE HOSPITAL	831 HWY 150 SOUTH EVANSTON, WY 82931

(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 Licensure of Hospitals, Chapter 12, effective 09/12/2012. A complaint survey was conducted by Healthcare Licensing and Surveys on 7/8/21. The survey was prompted by complaint intake LIC-20-018. Based upon the findings of the survey team, it was determined that no deficiencies were identified pertaining to the complaint. In addition, a COVID-19 focused infection control survey was conducted by Healthcare Licensing and Surveys on 7/8/21. It was determined, based upon the findings of the survey team, that no deficiencies were identified pertaining to the infection control survey.	S 000		