

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: WY9014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/17/2024
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NAME OF PROVIDER OR SUPPLIER MISSION AT THE VILLA	STREET ADDRESS, CITY, STATE, ZIP CODE 1445 UINTA DR GREEN RIVER, WY 82935
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(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
S8030	<p>Continued From page 1</p> <p>required could result in injury or death. The deficiency affected one (1) of multiple resident rooms in the facility. The findings were:</p> <p>Observation on 01/17/2024 at 2:57 PM in resident room 203 revealed an oxygen container placed freestanding in a closet. Oxygen containers must be secured against damage at all times.</p> <p>Interview with the facility administrator at the time of observation acknowledged the deficiency and indicated that she was aware of the requirement.</p> <p>Interview with the facility administrator at the time of exit acknowledged the deficiency.</p> <p>Ref: 2005 NFPA 99, Sec. 9.4.3.2, 9.7.2.3 (11), 9.4.3.4, 9.4.4.1</p>	S8030		