

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 532002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/14/2025
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NAME OF PROVIDER OR SUPPLIER WYOMING STATE HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 251 YELLOWSTONE RIVER ROAD EVANSTON, WY 82931
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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
S 000	<p>Opening Comments</p> <p>Rules and Regulations utilized for this survey are:</p> <p>Rules and Regulations for Licensure of Psychiatric Hospitals, Chapter 15, effective 06/18/1999.</p> <p>A complaint survey was conducted by Healthcare Licensing and Surveys from 11/12/25 to 11/14/25. The survey was prompted by complaint intake(s) LIC-24-041, LIC-24-050, LIC-24-084, LIC-24-094, LIC-25-036, LIC-25-038, LIC-25-051, LIC-25-063, and LIC-25-069. It was determined, based upon the findings of the survey team, that no deficiencies were identified pertaining to the complaint investigation.</p>	S 000		

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

[Handwritten Signature]
WVPJ11

TITLE
Administrator

(X6) DATE
12.1.25