

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 01/09/2026
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NAME OF PROVIDER OR SUPPLIER Hospice of Sweetwater County	STREET ADDRESS, CITY, STATE, ZIP CODE 333 Broadway Street, Suite 220 , Rock Springs, Wyoming, 82901
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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) COMPLETION DATE
S0000	<p>OPENING COMMENTS</p> <p>A re-visit survey was conducted on 12/11/25 through 1/9/26 for all previous deficiencies cited on 9/5/25. All deficiencies have been corrected, and no new noncompliance was found. The facility is in compliance with all regulations surveyed.</p>	S0000		

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Walter Mancoske</i>	TITLE Executive Director	(X6) DATE 1/16/2026
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