

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>ALF009</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>01/20/2026</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ABSAROKA SENIOR LIVING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2401 COUGAR AVENUE</b> <b>CODY, WY 82414</b>
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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>General Comments</p> <p>A Life Safety Code revisit survey was conducted on 01/20/2026 for all previous deficiencies cited on 10/08/2025. All deficiencies have been corrected, and no new noncompliance was found. The facility is in compliance with all requirements.</p>	{S 000}		

Wyoming Dept of Health, Aging Division, Healthcare Licensing and Surveys  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_