

FORM APPROVED

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 04/15/2026
NAME OF PROVIDER OR SUPPLIER Everwind Hospice			STREET ADDRESS, CITY, STATE, ZIP CODE 801 E 4th St., Ste 14D, Gillette, Wyoming, 82718	
(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 revisit survey was conducted on 4/15/26 for all previous deficiencies cited on 3/5/26. 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>Christy Rand RN</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>4/17/26</i>
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