


STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/08/2026
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NAME OF PROVIDER OR SUPPLIER Premier Bone and Joint Ambulatory Surgical Center	STREET ADDRESS, CITY, STATE, ZIP CODE 1909 Vista Drive , Laramie, Wyoming, 82070
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(4) 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
000	<p>OPENING COMMENTS</p> <p>Rules and Regulations utilized for this survey are:</p> <p>Rules and Regulations for Licensure of Ambulatory Surgical Centers, Chapter 5, effective 03/23/2003.</p> <p>A licensure survey was conducted by Healthcare Licensing and Surveys from 4/6/26 through 4/8/26. Based upon the findings of the survey team, it was determined the facility was in compliance with State requirements.</p>	S0000		

REGULATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE ASC Director	(X6) DATE 4-23-26
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