

Healthcare Licensing and Surveys

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ALF008 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 03/11/2026 |
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| NAME OF PROVIDER OR SUPPLIER SIERRA HILLS ASSISTED LIVING COMMUNITY | STREET ADDRESS, CITY, STATE, ZIP CODE 4606 NORTH COLLEGE DRIVE CHEYENNE, WY 82009 |
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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 |
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| S 000 | <p>OPENING COMMENTS</p> <p>Rules and Regulations utilized for this survey are:</p> <p>Rules and Regulations for Program Administration of Assisted Living Facilities, Chapter 12, effective 08/24/2020.</p> <p>Rules and Regulations for Licensure of Assisted Living Facilities, Chapter 4, effective 06/28/2001. A complaint survey was conducted by Healthcare Licensing and Surveys on 3/11/26. The survey was prompted by complaint intake LIC-26-033. It was determined by the survey team, that no deficiencies were identified pertaining to the complaint investigation.</p> | S 000 | | |
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Wyoming Dept of Health, Aging Division, Healthcare Licensing and Surveys
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____