

Healthcare Licensing and Surveys

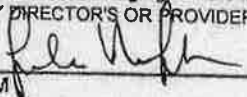
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ALF021 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED R 04/23/2026 |
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| NAME OF PROVIDER OR SUPPLIER WYOMING PIONEER HOME | STREET ADDRESS, CITY, STATE, ZIP CODE 141 PIONEER HOME DRIVE THERMOPOLIS, WY 82443 |
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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 revisit survey was conducted from 4/22/26 to 4/23/26 for all previous deficiencies cited on 2/25/26. All deficiencies have been found corrected, and no new noncompliance was found. The facility is in compliance with all regulations surveyed.</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

Administrator

(X6) DATE

5-6-26