

WDH - Office of Healthcare Licensing and Surveys

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 07/14/2011
NAME OF PROVIDER OR SUPPLIER WYOMING PIONEER HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 141 PIONEER HOME DRIVE THERMOPOLIS, WY 82443		
(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
SALF	LIC REGS FOR ASSISTED LIVING FACILITIES On 7/13/11 through 7/14/11 a complaint investigation was conducted at Wyoming Pioneer Home located in Thermopolis, Wyoming. It was determined, based upon the findings of the surveyor, that no deficiencies were identified pertaining to the complaint investigation.	SALF			

Wyoming Dept of Health, Office of Healthcare Licensing and Surveys

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE