

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ALF006	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 02/15/2013
NAME OF PROVIDER OR SUPPLIER ASPEN WIND ASSISTED LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 4010 NORTH COLLEGE DRIVE CHEYENNE, WY 82001		
(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 2/15/13 a complaint investigation was conducted for Aspen Wind Assisted Living located in Cheyenne, Wyoming. It was determined, based upon the findings of the survey team, that no deficiencies were identified pertaining to the complaint investigation		SALF		

Wyoming Dept of Health, Aging Division, Healthcare Licensing and Surveys

TITLE

(X6) DATE

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