

WDH - Office of Healthcare Licensing and Surveys

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 04/04/2011
NAME OF PROVIDER OR SUPPLIER SIERRA HILLS ASSISTED LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 4606 NORTH COLLEGE DRIVE CHEYENNE, WY 82009		
(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 A state complaint survey was conducted by the Office of Healthcare Licensing and Surveys on 4/4/11 at Sierra Hills Assisted Living Facility located in Cheyenne, Wyoming. Based upon the findings of the survey team, it was determined that this facility was in compliance with the state requirements.	SALF			

Wyoming Dept of Health, Office of Healthcare Licensing and Surveys

TITLE

(X6) DATE

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

STATE FORM

6899

PWMK11

If continuation sheet 1 of 1