

PRINTED: 02/22/2021
FORM APPROVED

Healthcare Licensing and Surveys			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ALF007	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____
NAME OF PROVIDER OR SUPPLIER POINTE FRONTIER RETIREMENT COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 1406 PRAIRIE AVENUE 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)
(S-000)	General Comments A revisit survey was conducted on 02/17/2021 for deficiencies identified on 01/22/2021. All deficiencies have been corrected, and the facility is now back in compliance.	(S 000)	

Wyoming Dept. of Health, Aging Division, Healthcare Licensing and Surveys
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Molly Sturman

TITLE

Interim Executive Director

(X8) DATE

2/22/2021

If continuation sheet 1 of 1

STATE FORM

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