

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 09/15/2021
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
S 000	General Comments Rules and Regulations for the survey are: Construction Rules and Regulations for Healthcare Facilities, Chapter 3, effective 04/03/2008 A complaint investigation was conducted by Healthcare Licensing and Surveys on 09/15/21. The survey was prompted by complaint intake LIC-21-026. It was determined, based on the findings of the survey, that no deficiencies were identified pertaining to the complaint.	S 000		

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

TITLE

(X6) DATE