

PRINTED: 10/14/2025  
FORM APPROVED

## Healthcare Licensing and Surveys

|                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                            |                                                                                                                          |                          |                                                                    |
|--------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>ALF007</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>10/01/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>POINTE FRONTIER RETIREMENT COMMUNIT</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1406 PRAIRIE AVENUE</b><br><b>CHEYENNE, WY 82009</b>                         |                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                       | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                    |
| {S 000}                                                                        | <p><b>OPENING COMMENTS</b></p> <p>Rules and Regulations utilized for this survey are:</p> <p>Rules and Regulations for Program<br/>Administration of Assisted Living Facilities,<br/>Chapter 12, effective 08/24/2020.</p> <p>Rules and Regulations for Licensure of Assisted<br/>Living Facilities, Chapter 4, effective 08/28/2001.<br/>An onsite revisit survey was conducted on<br/>10/1/25 for all previous deficiencies cited on<br/>5/28/25. All deficiencies have been corrected,<br/>and no new noncompliance was found. The<br/>facility is in compliance with all regulations<br/>surveyed.</p> | {S 000}                                                                    |                                                                                                                          |                          |                                                                    |

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

TITLE

(X6) DATE

Marianna Besserman, ED10-14-2025

STATE FORM

6850

IWKN12

If continuation sheet 1 of 1