

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 _____	(X3) DATE SURVEY COMPLETED 04/15/2026
--	---	---	---

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)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S 000	<p>OPENING COMMENTS</p> <p>Rules and Regulations utilized for this survey are:</p> <p>Rules and Regulations for Program Administration of Assisted Living Facilities, Chapter 12, effective 08/24/2020.</p> <p>Rules and Regulations for Licensure of Assisted Living Facilities, Chapter 4, effective 06/28/2001. A complaint survey was conducted by Healthcare Licensing and Surveys from 4/14/26 through 4/15/26. The survey was prompted by complaint intakes LIC-26-034, LIC-26-038, and LIC-26-044. It was determined by the survey team, that no deficiencies were identified pertaining to the complaint investigation.</p>	S 000		
-------	---	-------	--	--

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

Yarivanna Bussell

TITLE

Executive Director

(X8) DATE

4-29-2026