

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: WY9019	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/04/2026
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SUMMIT RIDGE ASSISTED LIVING AND MEMO	STREET ADDRESS, CITY, STATE, ZIP CODE 1110 BIRCH STREET DOUGLAS, WY 82633
--	---

(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>General Comments</p> <p>A Life Safety Code revisit survey was conducted by Healthcare Licensing and Surveys on 03/04/2026. The initial survey was performed on 11/13/2025, with a first revisit survey performed on 01/14/2026. All deficiencies have been corrected, and the facility is now back in compliance.</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