STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535040	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit Ridge Skilled Nursing & Rehabilitation	**1108 Birch Street , Douglas, Wyoming, 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) COMPLETION DATE
F0000	INITIAL COMMENTS A complaint survey was conducted by the Healthcare Licensing and Surveys from 4/28/26 through 4/30/26. The following common abbreviations are used throughout this document: BIMS: Brief Interview for Mental Status DON: Director of Nursing CNA: Certified Nursing Assistant Less commonly used abbreviations will be annotated in each deficiency.	F0000		
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observation, medical record review, and staff and resident interviews, the facility failed to ensure timely activities of daily living (ADL) care for dependent residents in 1 of 4 sampled residents (#3) reviewed for ADL care. The findings were: 1.Review of the 4/14/26 cognitive evaluation showed resident #3 had a BIMS score of 13 out of 15, which indicated the resident was cognitively intact. Review of a provider note dated 4/21/26 showed the resident required assistance with personal cares, was not ambulatory, and was unable to perform ADL's independently due to a recent above the knee amputation. Review of the care plan dated 4/13/26 showed the resident was dependent upon staff for incontinence care and had interventions which included "…Provide incontinence care after each incontinent episode…" and "…ADL needs will be met each day…" The following concerns were identified:	F0677	Plan of Correction F0677 CFR(s): 483.24(a)(2) The facility will ensure that a resident received timely activities of daily living (ADL). Corrective Action: Resident #3 was provided immediate assistance with ADL. All residents residing in the facility and that are incontinent have the potential to be affected. Systemic Change to prevent Recurrence: NHA or designee will educate staff on response times, correct call light usage, 2 person assists and incontinence cares to ensure all residents received assistance in a timely manner. Completion date: Training date for all staff to have additional training will be May 22, 2026. Responsible party: DON or designee will audit to ensure compliance with call light response times, appropriate 2 person assists, and appropriate	05/22/2026

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535040	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/30/2026

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F0677 SS = D	Continued from page 1 a. Observation on 4/28/26 at 1:56 PM showed resident #3's call light was on. At 1:58 PM an unidentified staff member entered the room and was told by the resident that two staff members were required to provide care. The staff member left the resident's room and the call light remained on. At 2:04 PM the unidentified staff member was observed entering the resident's room, turned off the call light, and exited the room. b. Interview with resident #3 on 4/28/26 at 2:05 PM revealed s/he had waited approximately 45 minutes for the return of two staff members to provide incontinence care and take him/her to the shower. The resident confirmed s/he was dependent upon staff for incontinence care. In addition, the resident revealed it was not unusual to wait an hour or more for incontinent care. c. Observation on 4/28/26 at 2:15 PM showed CNA #1, CNA #2, and CNA #3 entered the resident's room with a mechanical lift and provided incontinence care. The resident stated "Might as well take the gown off, it's soaking wet." Continued bservation showed the resident's bedding was removed and the mattress was wet. Interview with CNA #1 at that time confirmed the resident's brief and gown were wet. 2. Interview with the DON on 4/29/26 at 11:27 AM revealed "Anyone who requires assistance receives the care they need" and "Staff were expected to answer call lights and provide incontinence care at the time of need" 3. Review of the incontinence policy last revised 4/2025 showed "…All residents that are incontinent will receive appropriate treatment and services…"	F0677	Continued from page 1 incontinence care 5 times a week for 4 weeks, weekly for 4 weeks, then monthly for 4 months. QAPI: Audits will be brought to QAPI each month for 90 days or until resolved.	05/22/2026