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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit Ridge Skilled Nursing & Rehabilitation	1108 Birch Street Douglas, WY 82633

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 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: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 need3. Review of the incontinence policy last revised 4/2025 showed .All residents that are incontinent will receive appropriate treatment and services.

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 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