STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535040	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 06/16/2026

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
K0000 Bldg. 01	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Licensing and Surveys on 6/16/2026. Requirements for Long Term Care Facilities Section 42 CFR 483.90 except as otherwise provided in the Section, the facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code, Existing Health Care, of the National Fire Protection Association. The facility was a fully sprinklered, single story building with a basement of Type V (111) construction built in 1987 and 2010. The building was equipped with a supervised automatic wet sprinkler system with a dry branch, and an addressable fire alarm system. The facility had a capacity of 60 certified Medicare and Medicaid beds with a census of 49 residents. The findings that follow demonstrate noncompliance with 42 CFR 483.90.	K0000		
K0345 SS = F Bldg. 01	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is NOT MET as evidenced by: Based on document review and staff interview, the facility failed to provide evidence of maintenance for the fire alarm system in accordance with 2012 NFPA 101, Life Safety Code, and 2010 NFPA 72, National Fire Alarm and Signaling Code. Failure to test and maintain fire alarm systems could result in injury or death in the event of a fire. The deficiency could	K0345	The facility will ensure that documentation of testing and maintenance of the fire alarm system in accordance with 2012 NFPA 72, including Semi-annual inspection of lead-acid batteries-Table 14.3.1(3)(d) Semi-annual battery load voltage test-Table 14.4.5(6)(3) Smoke Detector sensitivity test-table 14.4.5(15)(i) Corrective Action: Facility Manager purchased a lead-acid battery tester and has tested batteries and recorded on 06/24/26. Facility manager performed battery load voltage test	07/22/2026

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

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K0345 SS = F Bldg. 01	Continued from page 1 affect the entire fire alarm system. The deficiency could affect all residents, staff, and visitors at the facility. The findings were: Document review on 06/16/2025 starting at 3:00 PM revealed the facility failed to provide documentation of testing and maintenance of the fire alarm system in accordance with 2010 NFPA 72. The facility failed to provide documentation of the following tests: a) Semi-annual inspection of lead-acid batteries - Table 14.3.1(3)(d) b) Semi-annual battery load voltage test - Table 14.4.5 (6)(3) c) Smoke Detector sensitivity test - Table 14.4.5(15)(i) Interview with the facility manager at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Section 9.6.3.1, 9.6.1.5 2010 NFPA 72, Tables 14.3.1, 14.4.5	K0345	Continued from page 1 on 06/24/26 Smoke detector sensitivity was performed by fire detection system on 07/01/26 Systemic Change to prevent Recurrence: Facility manager will ensure the following: a lead-acid batteries will be tested monthly and recorded in facility work order system monthly. battery load voltage test will be performed and recorded in facility work order system monthly Smoke detector sensitivity will be tested at least every 2 years and recorded in facility work order system. For each of these deficient practices, a calendar reminder has been placed to meet regulatory requirements. Completion date: 07/20/2026 Responsible party: Facilities manager or designee will ensure that the fire alarm testing and maintenance is performed semi-annually and uploaded to the test system. QAPI: NHA or designee will audit monthly for 3 months to review facility work order system and calendar reminder. Audits will be brought to QAPI each month for the next 3 months or until resolved.	07/22/2026
K0761 SS = F Bldg. 01	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance	K0761	K0761: Maintenance, Inspection & Testing-Doors CFR(s): NFPA 101 The facility will ensure to inspect the rolling fire related doors in accordance with the 2010 NFPA 80, Standards for Fire Doors and Other Opening Protectives. Corrective Action: Facility manager performed inspection on rolling fire doors to ensure they were in good working order, they sealed properly and	07/20/2026

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K0761 SS = F Bldg. 01	Continued from page 2 program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to inspect rolling fire-rated doors in accordance with the 2010 NFPA 80, Standard for Fire Doors and Other Opening Protectives. Failure to inspect rolling fire-rated doors as required could delay egress from the building during an emergency resulting in injury or death. The deficiency affected all rolling fire-rated doors in the building. The findings were: Document review on 6/16/2026 starting at 3:00 PM revealed that the rolling fire-rated doors had not been inspected during the 12 month period prior to the survey. Interview with the facility manager at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 8.3.3.1 2010 NFPA 80, Section 5.2.14.3	K0761	Continued from page 2 that the integrity of the door was sufficient in accordance to NFPA standards. All residents have the potential to be affected. Systemic Change to prevent Recurrence: Facility manager implemented check system to TELS system to ensure doors are checked monthly. Completion date: 07/20/26 Responsible party: Facility manager or designee QAPI: Monthly audits will be performed. Audits will be brought to QAPI each month for 3 months or until resolved. Administrator oversees the QAPI process and is ultimately responsible for corrective actions and sustained compliance.	07/20/2026
K0911 SS = F Bldg. 01	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99)	K0911	K0911: Electrical System- Other CFR(s): NFPA 101 The facility will ensure to provide a remote emergency stop for the emergency generator in accordance with 2012 NFPA 101, Life Safety Code, the 2012 NFPA 99, Healthcare Facilities Code, NFPA 110, Standard for Emergency Power Systems. Corrective Action: All obstacles that were on top of the filing cabinet were removed and the filing cabinet was moved away from the wall ensuring the box could open without delay. In addition, the box was labeled "Emergency Generator Stop Switch	07/20/2026

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K0911 SS = F Bldg. 01	Continued from page 3 This STANDARD is NOT MET as evidenced by: Based upon observation and staff interview, the facility failed to provide a remote emergency stop for the emergency generator in accordance with the 2012 NFPA 101, Life Safety Code, the 2012 NFPA 99, Healthcare Facilities Code, and NFPA 110, Standard for Emergency Power Systems. The failure to provide a remote method to shut down the generator as required could result in injury or death in the event of generator malfunction The deficiency affected one (1) of one (1) generators for the facility. The findings were: Observation on 6/16/2026 at 1:08PM revealed that the manual emergency stop for the generator was not labeled. Further observation revealed that the emergency stop was in a box which was prevented from opening by the placement of a filing cabinet and a large storage container next to the filing cabinet. The manual emergency stop is located within the generator panel, which is located in the former dining hall in the NW portion of the building. Discussions with the facility manager indicated that this location may no longer be a continuously monitored location pending functional use changes that are ongoing. If this does occur, the facility is aware that the location of the generator panel must be relocated to a continuously monitored location. Interview with the facility manager at the time of the observation acknowledged the deficiency, and indicated that he was area of the requirements. Interview with the Administrator at the time of exit acknowledged the deficiency. Ref: 2012 NFPA 101, Sections: 19.5.1, 9.1, 9.1.2, 9.1.3.1 2012 NFPA 99, Sections: 6.4.1, 6.4.1.1.16.2 and Table 6.4.1.1.16.2(v) 2010 NFPA 110 Sections 5.6.5.1(3), 5.6.5.2(3)(e), 5.6.5.6.1	K0911	Continued from page 3 located inside" All residents have the potential to be affected. Systemic Change to prevent Recurrence: Facilities manager placed board on floor between filing cabinet and wall to ensure cabinet does not encroach on box. Staff was educated on the importance of not placing objects on top of filing cabinet. Completion date: 07/20/26 Responsible party: Facilities manager or designee QAPI: 3 times a week for 12 weeks to ensure box is free from objects and can open freely. Audit will also include that the sign is still on the box and has not been removed. Audits will be brought to QAPI each month for 3 months or until resolved. Administrator oversees the QAPI process and is ultimately responsible for corrective actions and sustained compliance.	07/20/2026
K0918 SS = F Bldg. 01	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for	K0918	K0918 Essential Electric System Maintenance and Testing CFR(s): NFPA 101 The facility will ensure that the essential electrical system were tested and maintained in accordance with the 2012 NFPA 99, Healthcare Facilities code and the 2010 NFPA 110 Standard for Emergency and Standby Power System. Corrective Action: The facility has initiated documentation of monthly	07/20/2026

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K0918 SS = F Bldg. 01	Continued from page 4 the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on document review and staff interview, the facility failed to ensure essential electrical systems were tested and maintained in accordance with the 2012 NFPA 99, Healthcare Facilities Code, and the 2010 NFPA 110, Standard for Emergency and Standby Power Systems. Failure to test and maintain essential electrical systems could result in injury or death in the event of failure. The deficiencies could impact all patients, staff, and visitors. The findings were: 1) Document review on 06/16/2026 starting at 3:00 PM revealed the facility failed to provide documentation of monthly emergency generator lead-acid batteries specific gravity or conductance testing. 2) Document review on 06/16/2026 starting at 3:00 PM revealed the facility failed to provide documentation of Level 1 EPSS 4 hour testing every 36 months. 3) Document review on 06/16/2026 starting at 3:00 PM revealed the facility failed to provide documentation of an annual testing and maintenance program for essential electrical system feeders and breakers, according to manufacturer's	K0918	Continued from page 4 emergency generator lead-acid battery specific gravity or conductance testing. The facility has scheduled the 4 hour generator load test for 07/10/26 to be completed by generator company. Documentation of completion to follow. The facility has initiated testing of main and feeder circuit breaker and will document testing as per manufacturer instructions. Systemic Change to prevent Recurrence: Facility Manager will be educated on ensuring documentation of lead acid test is completed monthly, 4 hour load bank test is completed annually, and main and feeder circuit breaker is completed per manufacturer instructions. Each item has been added to our maintenance system. Completion date: 07/20/26 Responsible party: Facilities Manager or designee QAPI: NHA or designee will perform monthly audit to ensure completion of monthly tasks. Audits will be brought to QAPI each month for 90 days or until resolved.	07/20/2026

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K0918 SS = F Bldg. 01	Continued from page 5 recommendations. Interview with the facility manager at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 99, Sections: 6.4.4.1.2, 6.4.4.1.1.3 2010 NFPA 110, Sections: 8.3.7.1, 8.4.9	K0918		07/20/2026
K0222 SS = E Bldg. 01	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS	K0222	K0222: Egress Doors CFR(s): NFPA 101 The facility will ensure that egress doors are maintained in accordance with the 2012 NFPA 101, Life safety code. Egress Door Corrective Action: The magnetic doors by the MDS coordinator and Alzheimer's Coordinator office will be removed. All residents have the potential to be affected. Systemic Change to prevent Recurrence: Since the facility no longer has a special needs locking arrangement, the magnet on the locking unit doors will be removed. The doors will still close and are looped into our fire prevention system, but they will be able to be opened without the use of a code or key. Completion date: 07/20/26 Responsible party: Facility Manager or designee QAPI: Doors will be checked weekly x 4 weeks to ensure proper opening without use of code or key. Audits will be brought to QAPI each month for 90 days or until resolved. Administrator oversees the QAPI process and is ultimately responsible for corrective actions and sustained compliance.	07/20/2026

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K0222 SS = E Bldg. 01	Continued from page 6 Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This STANDARD is NOT MET as evidenced by: Based upon observation and staff interview, the facility failed to maintain egress doors in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain egress doors as required could delay egress resulting in injury or death during an emergency. The deficiency affected multiple exits in the facility, all of which were located within the former secured-unit. 1) Observation on 06/16/2026 at 12:18 PM at the doors by the MDS coordinator and Alzheimer Coordinator room found that when the doors were removed from the mag-holds, that the doors would lock with no approved delayed-egress system or access-controlled system. Doors were approved as a special needs locking arrangement, but are no longer being utilized in that fashion. 2) Observation on 06/16/26 at 12:30 PM at the west exit door revealed that the delayed-egress was not provided with signage as required by the Life Safety Code. Further observation found that several doors from the former memory care area were also missing the correct delayed-egress signage.	K0222	Continued from page 6 Door signage Corrective Action: The facility will ensure proper signage is on all exit doors as accordance with Life Safety Code. All residents have the potential to be affected. Systemic Change to prevent Recurrence: Ensuring compliance with all exit doors being clearly labeled with exit door signage and exit bar usage. Completion date: 07/20/26 Responsible party: Facility Manager or Designee QAPI: Facility manager or designee will ensure that each exit door has proper signage and that signage is visible. Audits will be brought to QAPI each month for 90 days or until resolved. Administrator oversees the QAPI process and is ultimately responsible for corrective actions and sustained compliance.	07/20/2026

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K0222 SS = E Bldg. 01	Continued from page 7 Interview with the facility manager at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Ref. 2012 NFPA 101: Section 19.2.2.2.4(2); 7.2.1.6.1.1 (4)	K0222		07/20/2026
K0211 SS = D Bldg. 01	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain a clear egress corridor in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain a clear means of egress as required could delay egress resulting in injury or death in the event of an emergency. The deficiency affected one (1) of multiple means of egress in the facility. The findings were: Observation on 06/16/2026 at 1:52 PM in the 300 hall dining room revealed chairs partially obstructing the emergency exit access door. Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. Interview with the facility manager at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Ref: 2012 NFPA 101, Sections 7.1.10	K0211	Plan of Correction K0211: Means of Egress: General CFR(s): NFPA 101 The facility will ensure that a clear egress corridor in accordance with the 2012 NFPA 101, Life Safety code. Corrective Action: The chair was immediately removed from blocking the egress. All residents have the potential to be affected. Systemic Change to prevent Recurrence: Staff will be educated to ensure that there are no obstacles blocking egress corridors. Completion date: 07/20/26 Responsible party: Facility manager or designee QAPI: Egress corridor audits will be completed 5 days a week for 4 weeks, 3 days a week for 4 weeks, and weekly for 4 weeks. Audits will be brought to QAPI each month for 3 months or until resolved.	07/20/2026

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K0291 SS = D Bldg. 01	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This STANDARD is NOT MET as evidenced by: Based on document review and staff interview, the facility failed to provide and test battery-operated emergency lighting equipment and exit signs in accordance with the 2012 NFPA 101, Life Safety Code. Failure to provide and test battery-operated emergency lighting equipment as required could result in inadequate lighting or failure to identify exit access during an emergency, resulting in injury or death. The deficiency impacted one battery-powered emergency light out of multiple throughout the facility. The findings were: Observation on 06/16/2026 at 1:00 PM in the generator enclosure revealed that a battery-powered light failed when put into test mode. In an emergency, failure of the battery-powered lighting could delay or prevent egress from the space. Interview with the facility manager at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Section: 19.2.9.1, 7.9	K0291	K0291 Emergency Lighting CFR(s): NFPA 101 The facility will ensure to provide and test battery-operated emergency lightening equipment and exit signs in accordance with the 2012 NFPA 101, Life Safety code. Corrective Action: The facility will ensure that the battery-operated light will engage when put into test mode. All residents have the potential to be affected. Systemic Change to prevent Recurrence: The outside generator emergency light will be added to monthly light checks to ensure that this light is tested during the monthly check list. Completion date: 07/20/26 Responsible party: Facility manager or designee. QAPI: Outside light will be added to monthly light check. Audits will be brought to QAPI each month for 3 months or until resolved. Administrator oversees the QAPI process and is ultimately responsible for corrective actions and sustained compliance.	07/20/2026
K0324 SS = D Bldg. 01	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke	K0324	K0324: Cooking Facilities CFR(s) 2012 NFPA 101 The facility will ensure that the kitchen extinguishing system is inspected in accordance with the 2012 NFPA 101 Life Safety Code and the 2011 NFPA 96, Standard for Ventilation control and Fire Protection of Commercial Cooking Operations. Corrective Action: The facility will ensure that the 2 inspections of the kitchen hood are completed annually. Hood inspection is scheduled for July 15, 2026. All residents have the potential to be affected.	07/20/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535040	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 06/16/2026

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

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K0324 SS = D Bldg. 01	Continued from page 9 compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to have the kitchen extinguishing system inspected in accordance with the 2012 NFPA 101, Life Safety Code, and the 2011 NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. Failure to have the kitchen extinguishing system inspected as required could result in injury or death during an emergency. The deficiency affected one (1) of one (1) kitchens in the facility. The findings were: Document review on 06/16/2026 starting at 3:00 PM revealed that one of the two inspections of the kitchen hood had been completed in the past 12 months. Interview with the facilities director at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Section 19.3.2.5.1, 9.2.32011 NFPA 96, Sections 11.5	K0324	Continued from page 9 Systemic Change to prevent Recurrence: Maintenance and Dietary will be educated in the importance of ensuring that the kitchen hood inspection are completed thoroughly and timely. Completion date: 07/20/26 Responsible party: Facility Manager or designee QAPI: Facility Manager or designee will audit that the hood inspection is complete. Audits will be brought to QAPI each month for 3 months or until resolved. Administrator oversees the QAPI process and is ultimately responsible for corrective actions and sustained compliance.	07/20/2026
K0923 SS = D Bldg. 01	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are	K0923	Gas Equipment-Cylinder and container Storage; 2012 NFPA 99 The facility will ensure to maintain gas cylinder storage in accordance with the 2012 NFPA 99. Corrective Action: All oxygen tanks are stored and secured properly in an O2 cage or stand, and not free standing. All residents have the potential to be affected. Systemic Change to prevent Recurrence: NHA or	07/20/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535040	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 06/16/2026

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K0923 SS = D Bldg. 01	Continued from page 10 not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain gas cylinder storage in accordance with the 2012 NFPA 99, Health Care Facilities Code. Failure to maintain gas cylinder storage as required could result in injury or death. The deficiency affected one (1) of numerous rooms in the facility. The findings were: Observation on 06/16/2026 at 1:41 PM at the oxygen room revealed an oxygen cylinder sitting unsecured on the floor. Interview with the facility manager at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Ref: 2012 NFPA 99: Sections 11.3.2.6, 11.6.2.3(11)	K0923	Continued from page 10 designee will educate all staff on ensuring that O2 tanks are properly secured and not left free standing. Completion date: 06/18/2026 Responsible party: Facility Manager or designee QAPI: Weekly audits will be performed to ensure O2 tanks are properly secured. Audits will be brought to QAPI each month for 3 months or until resolved. Administrator oversees the QAPI process and is ultimately responsible for corrective actions and sustained compliance.	07/20/2026

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 06/16/2026

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E0000	Initial Comments An emergency preparedness survey was conducted by Healthcare Licensing and Surveys on 06/16/2026. Based upon the findings of the survey, it was determined the facility was in compliance with all requirements of 42 CFR 483.73.	E0000		

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

Wyoming Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **06/16/2026**

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S0000 Bldg. 01	General Comments A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on 06/16/2026. Wyoming Department of Health, Rules and Regulations for Licensure of Nursing Care Facilities Chapter 19, Section 8 Life Safety and Electrical Safety. The requirements in the Department of Health Chapter III, Construction Rules and Regulations for Health Care Facilities apply. The facility was a fully sprinklered, single story building with a basement of Type V (111) construction built in 1987 and 2010. The building was equipped with a supervised automatic wet sprinkler system with a dry branch, and an addressable fire alarm system. The facility had a capacity of 60 certified Medicare and Medicaid beds with a census of 49 residents. The findings that follow demonstrate noncompliance with 42 CFR 483.90.	S0000		07/11/2026
S7036 Bldg. 01	Life Safety - Int'l Plumbing Code CFR(s): IPC This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain water temperatures in accordance with: the WDH Chapter 3 Construction Rules and Regulations for Healthcare Facilities; the 2006 International Plumbing Code (IPC); the 2006 Facility Guidelines Institute Guidelines for Design and Construction of Health Care Facilities (FGI); and the WDH Chapter 11: Program Administration of Nursing Care Facilities. Failure to maintain water temperatures as required could lead to burns on hands or other parts of the body leading to injury or death. The deficiencies were found at forty-six (46) handwash sinks, out of fifty-three (53) handwash sinks. The findings were: Document review on 06/16/2026 at starting 3:00 PM of a facility water temperature log for May revealed multiple rooms where the temperature at a hand wash sink was in excess of 110°F . Further interview with the facilities manager revealed that the sinks are equipped with ASSE 1070 mixing values, and are set to be below 120°F.	S7036	S2915: Physical environment; CFR(s): Ch 11 Sec 6 (a)(iv) The facility will ensure that hot water temperatures in hand washing sinks do not exceed 110 degrees Fahrenheit. Corrective Action: All hand washing sink temperatures were adjusted to appropriate temperature on 06/18/26. All residents have the potential to be affected. Systemic Change to prevent Recurrence: Facility Manager and NHA were educated on proper temperature per WDOH regulations. Completion date: 06/18/26 Responsible party: NHA or designee QAPI: Weekly Audits conducted by maintenance	07/20/2026

Office of Primary Care and Health Systems Management

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING **01 - MAIN BUILD...** B. WING	**06/16/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S7036 Bldg. 01	Continued from page 1 Interview with the facility manager at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. REF: WDH Chapter 11 Section 6, (a)(iv) 2006 IPC Section 416.5, Chapter 2 - tempered water 2006 FGI Section 40.1.2.2 and Table 4.1-3	S7036	Continued from page 1 team. Audits will be brought to QAPI each month for 3 months or until resolved. Administrator oversees the QAPI process and is ultimately responsible for corrective actions and sustained compliance.	07/20/2026