

WDH - Office of Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: WY0001	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2009
NAME OF PROVIDER OR SUPPLIER AMIE HOLT CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 497 W LOTT BUFFALO, WY 82834		
(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	
SNH	LIC REGS FOR NURSING HOMES This State Rules and Regulations is not met as evidenced by: A survey was conducted by the Office of Healthcare Licensing and Surveys on 11/16/09 through 11/19/09. Based upon the findings of the survey team, it was determined that this facility was in compliance with the state requirements.	SNH			

Wyoming Dept of Health, Office of Healthcare Licensing and Surveys

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

MK8U11

If continuation sheet 1 of 1