PRINTED: 11/14/2014
FORM APPROVED

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY0001	A. BUILDING: _____ B. WING _____	11/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMIE HOLT CARE CENTER	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
S3059	Ch 19 Sec 7 Construction/Remodeling Department of Health Chapter III, Construction Rules for Health Facilities apply. This State Rule and Regulation is not met as evidenced by: The Facility is not in compliance with WDH Chapter 3 rules and guidelines. Please refer to the following tag: 7036	S3059		
S7036	IPC Life Safety - Int'l Plumbing Code This State Rule and Regulation is not met as evidenced by: Observation of emergency eyewash stations throughout the facility on 11/04/14 from 1:50 PM to 3:45 PM revealed that tepid water was not provided via an ASSE 1071 mixing valve in compliance with ANSI Z358.1. At the time of the observation, the Maintenance Manager confirmed that the eyewash stations were not equipped with the appropriate mixing valve. (Reference 2006 IPC, Section 411)	S7036	Amie Holt Care Center will ensure that the emergency eyewash stations throughout the facility will meet the ANSI Z358.1 requirement by: A) The Maintenance Manger or designee will remove the emergency eyewash station in the activities department. B) The Maintenance Manager or designee will replace the emergency eyewash station with the Honeywell Portable Eyewash Station Mfr. Model # 32-001000-0000. This eyewash station is ANSI Z358.1-2009, SEI certified. C) The Maintenance Manager or designee will provide training for staff on the use of the new emergency eyewash station.	1/06/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 11/25/14

STATE FORM 6899 QF2L11 If continuation sheet 1 of 1

POC Accepted VIA Phone Call with Administrator Kent WARD on 12/4/14 at 9:38 AM LSC 34354