

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 01/28/2011
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 A recertification survey was conducted at Amie Holt Care Center located in Buffalo, Wyoming from 1/24/11 through 1/28/11. Based on the findings of the survey team, it was determined that no deficiencies were identified pertaining to the State regulations.	SNH		

Wyoming Dept of Health, Office of Healthcare Licensing and Surveys

TITLE

(X6) DATE

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