

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/28/2024  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                            |  |                                                                                  |                                                                                                                          |                                                        |                            |
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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>53A002</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>01</b><br><br>B. WING _____         |                                                                                                                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>03/05/2024</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>AMIE HOLT CARE CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                            |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>497 W LOTT<br/>BUFFALO, WY 82834</b> |                                                                                                                          |                                                        |                            |
| (X4) ID<br>PREFIX<br>TAG                                         | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                            |  | ID<br>PREFIX<br>TAG                                                              | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |                                                        | (X5)<br>COMPLETION<br>DATE |
| E 000                                                            | Initial Comments<br><br>An Emergency Preparedness survey was conducted by Healthcare Licensing and Surveys on 03/05/2024. Based on the findings of the survey team, it was determined that the facility was in compliance with all requirements in accordance with 42 CFR 483.73.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                            |  | E 000                                                                            |                                                                                                                          |                                                        |                            |
| K 000                                                            | INITIAL COMMENTS<br><br>A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on 03/05/2024.<br><br>Requirements for Long Term Care Facilities Section 42 CFR 483.90 except as otherwise provided in this 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.<br><br>The facility was a fully sprinklered, two story building of Type II(III) with plan approval in 2016. 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 44 certified Medicaid beds with a census of 30 residents. Based on the findings of the survey team, it was determined that the facility was in compliance with all requirements in accordance with 42 CFR 483.90. |                                                                            |  | K 000                                                                            |                                                                                                                          |                                                        |                            |

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

TITLE

(X6) DATE

Electronically Signed

03/14/2024

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.