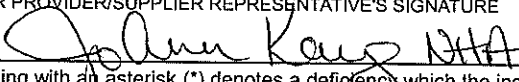


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/18/2025  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                  |                                                                                                                                                                                                                                                                                                                                                       |                                                                            |                                                                                                                          |                            |                                                                    |
|------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------------------|
| 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>R</b><br><b>06/13/2025</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</b><br><b>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 revisit survey was conducted via email by Healthcare Licensing and Surveys on 06/13/2025 for deficiencies identified on 04/24/2025. All deficiencies have been corrected, and no new noncompliance was found. The facility is in compliance with all requirements in accordance with 42 CFR 483.73. | {E 000}                                                                    |                                                                                                                          |                            |                                                                    |
| {K 000}                                                          | INITIAL COMMENTS<br><br>A Life Safety Code revisit survey was conducted via email on 06/13/2025 for deficiencies identified on 04/24/2025. All deficiencies have been corrected, and no new noncompliance was found. The facility is in compliance with all requirements in accordance with 42 CFR 483.90.                                            | {K 000}                                                                    |                                                                                                                          |                            |                                                                    |

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

Electronically Signed  NHA

TITLE

NHA

(X6) DATE

7/18/25

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.