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

POST-CERTIFICATION REVISIT REPORT

PROVIDER/SUPPLIER/CLIA/IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
535042	A. Building ______ B. Wing ______	7/27/05

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
Shepherd of the Valley	60 Magnolia, Casper, WY 82604

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F Reg. # 203 LSC ____	Correction Completed 7/27/05	ID Prefix ____ Reg. # ____ LSC ____	Correction Completed __/__/__	ID Prefix ____ Reg. # ____ LSC ____	Correction Completed __/__/__
ID Prefix ____ Reg. # ____ LSC ____	Correction Completed __/__/__	ID Prefix ____ Reg. # ____ LSC ____	Correction Completed __/__/__	ID Prefix ____ Reg. # ____ LSC ____	Correction Completed __/__/__
ID Prefix ____ Reg. # ____ LSC ____	Correction Completed __/__/__	ID Prefix ____ Reg. # ____ LSC ____	Correction Completed __/__/__	ID Prefix ____ Reg. # ____ LSC ____	Correction Completed __/__/__
ID Prefix ____ Reg. # ____ LSC ____	Correction Completed __/__/__	ID Prefix ____ Reg. # ____ LSC ____	Correction Completed __/__/__	ID Prefix ____ Reg. # ____ LSC ____	Correction Completed __/__/__
ID Prefix ____ Reg. # ____ LSC ____	Correction Completed __/__/__	ID Prefix ____ Reg. # ____ LSC ____	Correction Completed __/__/__	ID Prefix ____ Reg. # ____ LSC ____	Correction Completed __/__/__

REVIEWED BY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
STATE AGENCY ☐			Jean McC[illegible]	7/27/05
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE: RD Acting Mgr	

FOLLOWUP TO SURVEY COMPLETED ON 6/15/05

☐ CHECK ( ) FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

Form CMS-2567B (9-92)

CMS REGIONAL OFFICE