

WDH - Office of Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: WY0027	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/25/2010
NAME OF PROVIDER OR SUPPLIER SHEPHERD OF THE VALLEY CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 60 MAGNOLIA CASPER, WY 82604		
(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 This State Rules and Regulations is not met as evidenced by: A survey was conducted by the Office of Healthcare Licensing and Surveys on 3/22/10 through 3/25/10. Based upon the findings of the survey team, it was determined that this facility was in compliance with the state requirements.	SNH		

Wyoming Dept of Health, Office of Healthcare Licensing and Surveys

TITLE

(X6) DATE

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

STATE FORM

6899

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If continuation sheet 1 of 1