STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535042	A. BUILDING **01, 02** B. WING _____	R **10/06/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEPHERD OF THE VALLEY REHABILITATION AND WELLNESS	**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) COMPLETION DATE
{E 000}	Initial Comments An Emergency Preparedness revisit survey was conducted by Healthcare Licensing and Surveys on 10/06/2023 for deficiencies cited on 08/09/2023. All deficiencies have been corrected, and the facility is now in compliance with all requirements in accordance with 42 CFR 483.73.	{E 000}		
{K 000}	INITIAL COMMENTS A Life Safety Code revisit was conducted on 10/06/2023 for all previous deficiencies cited on 08/08/2023 and 08/09/2023. All deficiencies have been corrected, and no new noncompliance was found. The facility is now in compliance with all requirements in accordance with 42 CFR 483.90.	{K 000}		
{K 000}	INITIAL COMMENTS A Life Safety Code revisit was conducted on 10/06/2023 for all previous deficiencies cited on 08/08/2023 and 08/09/2023. All deficiencies have been corrected, and no new noncompliance was found. The facility is now 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 | 10/13/2023

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.