

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 R 10/06/2023
NAME OF PROVIDER OR SUPPLIER SHEPHERD OF THE VALLEY REHABILITATION		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
{S 000}	General 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 in compliance with all regulations surveyed.	{S 000}		

Wyoming Dept of Health, Aging Division, Healthcare Licensing and Surveys
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

10/13/23