

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

PRINTED: 03/20/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535042		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01, 02 B. WING _____		(X3) DATE SURVEY COMPLETED R 12/17/2024	
NAME OF PROVIDER OR SUPPLIER SHEPHERD OF THE VALLEY REHABILITATION AND WELLNESS				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) COMPLETION DATE
{K 000}	INITIAL COMMENTS A Life Safety Code Follow up Survey was conducted on 12/17/2024 by Healthcare Licensing and Surveys to assess compliance for all previous deficiencies identified during the survey conducted on 10/29/2024. Based on the findings of the survey, all previously identified non-compliance has been corrected, and the facility is in compliance with all requirements in accordance with CFR 483.90.			{K 000}			
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

01/03/2025

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.