Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY9088	A. BUILDING: _____ B. WING _____	C 11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
7 MOONS WELLNESS	1432 EAST 2ND STREET CASPER, WY 82601

(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	OPENING COMMENTS Rules and Regulations utilized for this survey are: Rules and Regulations for Program Administration of Home Health Agencies, Chapter 9, effective 10/15/2001. Rules and Regulations for Licensure of Home Health Agencies, Chapter 10, effective 11/01/2001. An initial licensure survey was conducted by Healthcare Licensing and Surveys from 11/3/25 to 11/5/25. Also reviewed in the course of the survey was complaint intake WY...LIC-25-064. The following common abbreviations are used throughout this document: CNA: Certified Nursing Assistant DME: Durable Medical Equipment Less commonly used abbreviations will be annotated in each deficiency.	S 000		
S1901	Ch 9 Sec 5 (a)(ii) Organization and Administration (a) Governing Body. The home health agency shall have a governing body which has legal authority and responsibility to operate the home health agency. The governing body shall: (ii) Provide verification of a central registry check on all employees hired at the time of, or after, the filing of these rules. The individual, agencies or corporations are responsible to initiate and follow this process to completion. Central Registry information can be obtained by contacting the Department of Family Services at 307-777-5894. (This number may be	S1901		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Terrill Sullivan — TITLE: Provider — (X6) DATE: 12/2/2025

Changes made per phone call with Terrill Sullivan on 12/12/25 @ 10:50am.
POC accepted.

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY9088	A. BUILDING: _____ B. WING _____	C 11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
7 MOONS WELLNESS	1432 EAST 2ND STREET CASPER, WY 82601

(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
S1901	Continued From page 1 subject to change.) This State Rule and Regulation is not met as evidenced by: Based on personnel record review, and staff interview the agency failed to ensure Central Registry checks were completed for 4 of 5 sample staff reviewed (CNA #1, CNA #2, CNA #3, CNA #4). The findings were: 1. Review of the personnel record for CNA #1 showed a hire date of 8/28/25. However, there was no evidence a Central Registry check was performed. 2. Review of the personnel record for CNA #2 showed a hire date of 3/21/25. However, there was no evidence a Central Registry check was performed. 3. Review of the personnel record for CNA #3 showed a hire date of 9/30/25. However, there was no evidence a Central Registry check was performed. 4. Review of the personnel record for CNA #4 showed a hire dated of 9/11/25. However, there was no evidence a Central Registry check was performed. 5. Interview with the Office Manager on 11/5/25 at 11 AM revealed the agency did not have a policy for Central Registry Checks. 6. Interview with the Administrator on 11/5/25 at 12 PM revealed the prior Human Resource Manager did not print the Central Registry Reports on the staff, and did not put them in the personnel records. She stated she was sure the	S1901		

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY9088	A. BUILDING: _____ B. WING _____	C 11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
7 MOONS WELLNESS	1432 EAST 2ND STREET CASPER, WY 82601

(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
S1901	Continued From page 2 staff were checked. However, she did not have access to the results to print them off.	S1901		
S1906	Ch 9 Sec 5 (a)(vii) Organization and Administration (a) Governing Body. The home health agency shall have a governing body which has legal authority and responsibility to operate the home health agency. The governing body shall: (vii) Develop an effective, ongoing, agency-wide written quality management program which ensures and evaluates quality of care provided to all clients in accordance with W.S. §35-2-910. This State Rule and Regulation is not met as evidenced by: Based on staff interview the agency failed to ensure the development of a quality management program. The findings were: Interview with the administrator on 11/5/25 at 1:45 PM revealed the agency did not have a quality management program. She stated she was unaware of the agency needing one.	S1906		
S1908	Ch 9 Sec 5 (a)(ix) Organization and Administration (a) Governing Body. The home health agency shall have a governing body which has legal authority and responsibility to operate the home health agency. The governing body shall:	S1908		

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY9088	A. BUILDING: _____ B. WING _____	C 11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
7 MOONS WELLNESS	1432 EAST 2ND STREET CASPER, WY 82601

(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
S1908	Continued From page 3 (ix) Complaint Investigations. (A) Client's complaints and problems shall be referred in writing to the State Long Term Care Ombudsman. (B) The Office of the Ombudsman shall complete all complaint investigations within an appropriate time frame depending upon the seriousness of the allegations. (C) Written reports of investigations and the status of resolutions completed by the home health agency shall be provided by the State Long Term Care Ombudsman to the Licensing Division, within thirty (30) days after the completion of the investigation. Exception: Those complaints or problems reported directly to the State Survey Agency or referred by the State Long Term Care Ombudsman to the State Survey Agency shall be investigated by the State Survey Agency as per the Agreement between the Secretary of the U.S. Department of Health and Human Services and the State of Wyoming dated June 16, 1985. This State Rule and Regulation is not met as evidenced by: Based on policy review, client handbook review, and staff interview the agency failed to ensure the State Survey Agency information was included. The findings were: 1. Review of the policy "Grievance Procedure for Home Health and Waiver Service" hand delivered on 11/4/25 at 8:30 AM by administration staff titled "...External Grievance Resources" revealed it failed to include the State Survey Agency.	S1908		

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY9088	A. BUILDING: _____ B. WING _____	C 11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
7 MOONS WELLNESS	1432 EAST 2ND STREET CASPER, WY 82601

(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
S1908	Continued From page 4 2. Review of the client admission client packet hand delivered on 11/4/25 at 10:14 AM by administration staff showed the policy for Grievance Procedure was included. However, all the external grievance resources, names with phone numbers and addresses were not included. Further, the Wyoming State Home Health hotline number was not included. 3. Interview with the administrator on 11/4/25 at 10:14 AM confirmed the list of external resources was missing. In addition, she confirmed the State Survey Agency was not on the list for clients to contact.	S1908		
S1911	Ch 9 SEc 5 (a)(xii) Organization and Administration (a) Governing Body. The home health agency shall have a governing body which has legal authority and responsibility to operate the home health agency. The governing body shall: (xii) Advanced Directives. (A) The home health agency shall adopt policies which assure that it provides information on advanced directives to clients. If the client's advanced directives are known, they shall be followed by the home health agency. This State Rule and Regulation is not met as evidenced by: Based on medical records review, admission client packet review, policy review and staff interview the agency failed to ensure advance directives were provided for 7 of 7 clients	S1911		

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY9088	A. BUILDING: _____ B. WING _____	C 11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
7 MOONS WELLNESS	1432 EAST 2ND STREET CASPER, WY 82601

(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
S1911	Continued From page 5 reviewed (#1, #2, #3, #4, #5, #6, #7). The findings were: 1. Review of the medical record for client #1 revealed it failed to include advance directives. 2. Review of the medical record for client #2 revealed it failed to include advance directives. 3. Review of the medical record for client #3 revealed it failed to include advance directives. 4. Review of the medical record for client #4 revealed it failed to include advance directives. 5. Review of the medical record for client #5 revealed it failed to include advance directives. 6. Review of the medical record for client #6 revealed it failed to include advance directives. 7. Review of the medical record for client #7 revealed it failed to include advance directives. 8. Review of the admission client packet hand delivered on 11/4/25 at 10:14 AM by administration staff member revealed it failed to include information related to advance directives. 9. Interview with the administator on 11/4/25 at 10:14 AM verified the advance directives were missing from the resident records. She stated she was unaware they needed to be done, and maintained within the records until recently. Further, she revealed there was not a policy on advance directives. 10. Interview with CNA #5 on 11/4/25 at 11 AM revealed she would look at the plan of care for the advance directives.	S1911		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY9088	A. BUILDING: _____ B. WING _____	C 11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
7 MOONS WELLNESS	1432 EAST 2ND STREET CASPER, WY 82601

(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
S1912	Ch 9 Sec 5 (a)(xiii) Organization and Administration (a) Governing Body. The home health agency shall have a governing body which has legal authority and responsibility to operate the home health agency. The governing body shall: (xiii) Clients' Rights. (A) A home health client has the right to: (I) Be treated with dignity, consideration and respect. (II) Have is/her property treated with respect. (III) Receive a timely response to his/her request for service. (IV) Be fully informed upon admission of the care and treatment that will be provided, how much it will cost, and how payment will be handled. (V) Be informed in advance of any changes in care to be furnished. (VI) Be informed in advance if he/she will be responsible for any payment. (VII) Receive care from professionally trained personnel. Be informed of the names and responsibilities of care providers, and to have the right of choice in care providers. (VIII) Participate in designing a care plan, and periodically updating it as his/her condition changes. Refuse treatment and to be	S1912		

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY9088	A. BUILDING: _____ B. WING _____	C 11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
7 MOONS WELLNESS	1432 EAST 2ND STREET CASPER, WY 82601

(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
S1912	Continued From page 7 told the consequences of his/her actions. (IX) Expect confidentiality of all information related to his/her care, within required regulations. (X) Be informed within a reasonable time of anticipated termination of service. Be referred elsewhere, if he/she is denied services based solely on his/her ability to pay. (XI) Authorize discontinuation of treatment which will be respected in accordance with the home health agency's policy. (XII) Know how to make a complaint or grievance or recommend changes in agency policies and services, and have the freedom to do so. (XIII) Call the home health agency administration during regular office hours. (XIV) Call a home health hotline number as provided by the provider. This State Rule and Regulation is not met as evidenced by: Based on medical record review, staff interview, and policy review the agency failed to ensure clients' rights to participate in their care plan, treatment plan, times of appointments and who would be providing cares, and were given the home health hotline number for 7 of 7 clients reviewed (#1, #2, #3, #4, #5, #6, #7). The findings were: 1. Review of the admission client packet hand delivered on 11/4/25 at 10:14 AM by	S1912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY9088	A. BUILDING: _____ B. WING _____	C 11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
7 MOONS WELLNESS	1432 EAST 2ND STREET CASPER, WY 82601

(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
S1912	Continued From page 8 administration, failed to show it included the home health hotline. Pertaining to the plan of care: 1. Review of the medical record for client #1 showed the agency failed to develop a plan of care. Instead, the agency was using the: "Wyo Medicaid Division of Healthcare Financing" Case Manager's Assessment Results. The assessment failed to include the client's birthday, client's diagnosis, clients' allergies, insurance information, list of medications, the advance directives, the client goals, precautions, and durable medical equipment. However, the assessment did show the agency was to provide Personal Support Services "24-per week", and Home Health Aide "24-per week", and Homemaker services "12-per week". Further, it did not break down the times per day, nor directed the service further then what the was authorized by the case manager for the agency services. 2. Review of the medical record for client #2 showed the agency failed to develop a plan of care. Instead, the agency was using the: "Wyo Medicaid Division of Healthcare Financing" Case Manager's Assessment Results. The assessment failed to include the client's birthday, client's diagnosis, clients' allergies, insurance information, list of medications, the advance directives, the client goals, precautions, and durable medical equipment. However, the assessment did show the agency was to provide Home Health Aide "24-per week", and Homemaker services "12-per week". Further, the document did not break down the times per day, nor directed the service further then what the was authorized by the case manager for the agency	S1912		

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY9088	A. BUILDING: _____ B. WING _____	C 11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
7 MOONS WELLNESS	1432 EAST 2ND STREET CASPER, WY 82601

(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
S1912	Continued From page 9 services. 3. Review of the medical record for client #3 showed the agency failed to develop a plan of care. Instead, the agency was using the: "Wyo Medicaid Division of Healthcare Financing" Case Manager's Assessment Results. The assessment failed to include the client's birthday, client's diagnosis, clients' allergies, insurance information, list of medications, the advance directives, the client goals, precautions, and durable medical equipment. However, the assessment did show the agency was to provide Home Health Aide "18-per week", and Homemaker services "12-per week". Further, the document did not break down the times per day, nor directed the service further then what the was authorized by the case manager for the agency services. 4. Review of the medical record for client #4 showed the agency failed to develop a plan of care. Instead, the agency was using the: "Wyo Medicaid Division of Healthcare Financing" Case Manager's Assessment Results. The assessment failed to include the client's birthday, client's diagnosis, clients' allergies, insurance information, list of medications, the advance directives, the client goals, precautions, and durable medical equipment. However, the assessment did show the agency was to provide Home Health Aide "20-per week", and Homemaker services "12-per week". Further, the document did not break down the times per day, nor directed the service further then what the was authorized by the case manager for the agency services. 5. Review of the medical record for client #5 showed the agency failed to develop a plan of	S1912		

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY9088	A. BUILDING: _____ B. WING _____	C 11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
7 MOONS WELLNESS	1432 EAST 2ND STREET CASPER, WY 82601

(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
S1912	Continued From page 10 care. Instead, the agency was using the: "Wyo Medicaid Division of Healthcare Financing" participant service summary. The agency did not have the case management assessment. The participant of service showed the agency was to get with the client to set day a time that worked best for him/her for personal support service, homemaker, and home health aide, with the start date of 5/1/25 and end date of 4/30/26. 6. Review of the medical record for client #6 showed the agency failed to develop a plan of care. Interview with the administrator on 11/5/25 at 1:25 PM revealed the case manager discontinued services, and did not have the case manangement assessment. 7. Review of the medical record for client #7 showed the agency failed to develop a plan of care. Instead, the agency was using the: "Wyo Medicaid Division of Healthcare Financing" Case Manager's Assessment Results. The assessment failed to include the client's birthday, client's diagnosis, clients' allergies, insurance information, list of medications, the advance directives, the client goals, precautions, and durable medical equipment. However, the assessment did show the agency was to provide Home Health Aide "8-per week", and Homemaker services "4-per week". Further, the document did not break down the times per day, nor directed the service further then what the was authorized by the case manager for the agency services. 8. Interview with the office manager on 11/5/25 at 10 AM confirmed the agency used the case manager assessment as the plan of care. 9. Review of policy "7 Moons Wellness- Client Rights and Responsibilities" hand delivered on	S1912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY9088	A. BUILDING: _____ B. WING _____	C 11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
7 MOONS WELLNESS	1432 EAST 2ND STREET CASPER, WY 82601

(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
S1912	Continued From page 11 11/4/25 at 8:30 AM by administration showed "...3. Participated in Care. Be informed of your care plan and participate in the planning of your care..."	S1912		
S1914	Ch 9 Sec 6 (a)-(d) Home Health Aide (a) Must be a CNA and have completed training to ensure competency in the home setting. This training must be documented and retained in the employee personnel record. (b) If the client requires skilled services in the home, the home health aide must be supervised by a RN or LPN at least every thirty (30) days. (c) Provide personal care for the client in the home. (d) Instructions based upon written care plans shall be provided to home health aides by the supervisory nurse at least every sixty (60) days or as the client's condition warrants. This State Rule and Regulation is not met as evidenced by: Based on medical record review, personnel record review, client interview, staff interview, and policy review, the agency failed to ensure CNAs had completed training to ensure competency in the home setting for 4 of 4 sample CNAs reviewed (CNA #1, CNA #2, CNA #3, CNA #4), and failed it ensure supervisory visits were performed, and failed to provide cares as requested. The findings were: Pertaining Wyoming State Home Health Aide certification:	S1914		

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY9088	A. BUILDING: _____ B. WING _____	C 11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
7 MOONS WELLNESS	1432 EAST 2ND STREET CASPER, WY 82601

(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
S1914	Continued From page 12 1. Review of the personnel record for CNA #1 showed a hire date of 8/28/25. However, there was no evidence of a Home Health Aide training was performed or started. 2. Review of the personnel record for CNA #2 showed a hire date of 3/21/25. However, there was no evidence of a Home Health Aide training was performed or started. 3. Review of the personnel record for CNA #3 showed a hire date of 9/30/25. However, there was no evidence of a Home Health Aide training was performed or started. 4. Review of the personnel record for CNA #4 showed a hire date of 9/11/25. However, there was no evidence of a Home Health Aide training was performed or started. 5. Interview with the Administrator on 11/5/25 at 12 PM revealed she was unaware the CNAs needed the Home Health Aide certificate. Pertaining to supervisory nurse visits: 1. Review of the 7 sample clients records showed the agency failed to perform supervisory visits on 2 of 7 sample clients (#1, #4). There were no supervisory visits performed. Pertaining to provide personal care for clients in home: 1. Review of the assessment client #1 (agency using as the plan of care) showed the aide was to visit 24 times a week, failing to show any specifics on length of time per visit or to structure the times for consistency and staff assigned. Observation on 11/4/25 at 2:15 PM showed the	S1914		

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY9088	A. BUILDING: _____ B. WING _____	C 11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
7 MOONS WELLNESS	1432 EAST 2ND STREET CASPER, WY 82601

(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
S1914	Continued From page 13 aide assigned for the home visit failed to show. The client and State Survey Agency Staff waited over 45 minutes for another aide to arrive and provide the cares. 2. Observation on 11/4/25 at 12 PM showed the aide assigned to provide cares failed to show for the appointment. Interview with the client at that time revealed s/he was looking forward to a shower, and help taking down decorations. Review of the client's assessment (agency using as the plan of care) showed the aide was to visit 18 times a week. Review of the "Service Review" document start date 11/3/25 showed "...I am requesting this service be provided 3 hour(s) every week from 11/3/2025 to 8/31/2026. 3. Review of the assessment for client #4 (agency using as the plan of care) showed the aide was to visit 20 times a week, failing to show any specifics on length of time per visit or to structure the times for consistency and staff assigned. Review of the "Service Review" document start date 4/7/25 showed "... I am requesting this service be provided 5 hour (s) every day from 4/7/2025 to 2/28/2026...Status History: Referral Added, Please get with [client name] to set schedule and hours that will work, dated 4/1/25..." Review of the August 2025 schedule showed the aids visited 17 out of 31 days and provided less than 5 hours of services per day, failing to follow the agreed time frame. 4. Interview with the administrator on 11/5/25 at 12 PM revealed she was unaware of the need for supervisory visits. She also, confirmed that some of the aides are not showing up for the assigned home visits, and not notifying the agency. 5. Review of policy 7 Moons Staff Responsibilities	S1914		

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY9088	A. BUILDING: _____ B. WING _____	C 11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
7 MOONS WELLNESS	1432 EAST 2ND STREET CASPER, WY 82601

(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
S1914	Continued From page 14 Policy hand delivered on 11/4/25 at 8:30 AM by administration showed " ...4. Timeliness and Scheduling. Arrive for scheduled visits on time. Notify the agency promptly if delayed, unable to report, or if schedule changes are needed. Document visit times accurately".	S1914		
S1917	Ch 9 Sec 7 (b)(ii) Homemaker (b) The homemaker assists with instrumental activities of daily living, such as housekeeping and homemaking services, in order to preserve a safe, sanitary home and to enhance family life. The homemaker does not provide any personal care. (ii) Written service plan instructions to the homemaker shall be provided by the supervising professional This State Rule and Regulation is not met as evidenced by: Based on medical record review and staff interview the agency failed to ensure a written service plan was written for 5 of 7 client sampled (#1, #2, #3, #4, #7). The findings were: 1. Review of the medical record for client #1 showed the agency failed to develop a plan of care. Instead, the agency was using the: "Wyo Medicaid Division of Healthcare Financing" Case Manager's Assessment Results. The agency was to provide Homemaker services "12-per week". Further, review showed no service plan for the homemaker service. 2. Review of the medical record for client #2 showed the agency failed to develop a plan of	S1917		

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY9088	A. BUILDING: _____ B. WING _____	C 11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
7 MOONS WELLNESS	1432 EAST 2ND STREET CASPER, WY 82601

(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
S1917	Continued From page 15 care. Instead, the agency was using the: "Wyo Medicaid Division of Healthcare Financing" Case Manager's Assessment Results. The agency was to provide Homemaker services "12-per week". Further, review showed no service plan for the homemaker service. 3. Review of the medical record for client #3 showed the agency failed to develop a plan of care. Instead, the agency was using the: "Wyo Medicaid Division of Healthcare Financing" Case Manager's Assessment Results. The agency was to provide Homemaker services "12-per week". Further, review showed no service plan for the homemaker service. 4. Review of the medical record for client #4 showed the agency failed to develop a plan of care. Instead, the agency was using the: "Wyo Medicaid Division of Healthcare Financing" Case Manager's Assessment Results. The agency was to provide Homemaker services "12 per week". Further, review showed no service plan for the homemaker service. 5. Review of the medical record for client #7 showed the agency failed to develop a plan of care. Instead, the agency was using the: "Wyo Medicaid Division of Healthcare Financing" Case Manager's Assessment Results. The agency was to provide Homemaker services "4-per week". Further, review showed no service plan for the homemaker service. 6. Interview with the Administrator on 11/5/25 at 12 PM revealed she was unaware the homemaker needs a guidance plan written.	S1917		

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY9088	A. BUILDING: _____ B. WING _____	C 11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
7 MOONS WELLNESS	1432 EAST 2ND STREET CASPER, WY 82601

(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
S1921	Continued From page 16	S1921		
S1921	Ch 9 Sec 8 (a)-(c) Client Records (a) Must be maintained for every client receiving services. (b) Client records must be retained for a period of six (6) years by the agency. (c) All client records must be safeguarded against loss or unauthorized use. This State Rule and Regulation is not met as evidenced by: Based on medical record review and staff interview the agency failed to ensure records were retained for 1 of 7 clients reviewed (#7). The findings were: 1. Review of the medical record for client #7 showed the start of care was 8/11/25 and the client was discharged on 8/28/25. The record showed the staff home visit schedule; however, the client assessment and plan of care were not present. 2. Interview with the Administrator on 11/5/25 at 1:25 PM revealed the Case Manager discontinued the client services with the agency, and the agency did not have the assessment.	S1921		

PLAN OF CORRECTION – CENTRAL REGISTRY CHECKS

Deficiency: S1901

Failure to complete required Central Registry checks for new CNA employees (CNA #1, #2, #3, and #4) and absence of an agency policy governing Central Registry checks.

---

1. Corrective action for the identified affected staff

- Repeated Central Registry checks were initiated immediately for CNA #1, CNA #2, CNA #3, and CNA #4.
- Results were reviewed upon receipt and placed in each employee's personnel file.
- Any necessary follow-up actions, based on the results, will be completed promptly.

Completion Date: *November 5th, 2025 -November 26, 2025*

---

2. Identification of other staff potentially affected

- A review of all current employee personnel files was initiated on **November 6th, 2025,** to ensure a Central Registry check is present for every staff member hired within the past 24 months.
- For any employee missing the required documentation, a repeated Central Registry check was completed immediately, and the results were placed in the personnel file.

Completion Date: *November 5th, 2025 -November 26, 2025*

---

3. Systemic changes to prevent recurrence

- A new written **Central Registry Check Policy** will be developed and implemented by **12/01/2025.** The policy will require:
  - Central Registry checks for all prospective employees before client contact.
  - Documentation of the completed check in the personnel file before the hire date;
  - A secondary review by the Office Manager to ensure compliance before onboarding is finalized.
- The Office Manager, Human Resources, and Administrator will receive training on the new policy and procedures by 12/01/2025.

Completion Date: *12/01/2025*

4. Monitoring to ensure sustained compliance

- Beginning **12/01/2025**, the Human Resource Director will conduct a **monthly audit** of 100% of newly hired employee files for three months to ensure Central Registry checks are completed and filed before hire.
- After the initial three months, the audit frequency will move to **quarterly** as part of the agency's Quality Assurance (QA) program.
- Audit results will be reviewed during QA meetings and corrective action taken immediately if deficits are identified.
- Monitoring will continue indefinitely as part of the agency's QA system.

Completion Date: *12/30/2025*

Tag #1906 Ch 9 Sec 5 (a)(vii) Organization and AdministrationTag: Governing Body – Quality Management Program
Deficient Practice:

The governing body failed to develop and maintain an effective, ongoing, agency-wide written Quality Management Program (QMP) to ensure and evaluate the quality of care provided to all clients.

Corrective Action Taken for the Affected Issue

The Administrator drafted and implemented a comprehensive, agency-wide written Quality Management Program (QMP) that includes:

- Quality indicators and performance measures
- A schedule for routine monitoring and data collection
- Procedures for identifying problems and implementing corrective action
- Quarterly QMP meeting requirements
- Documentation requirements and annual evaluation processes

The governing body reviewed, approved, and adopted the QMP on **12/01/2025**. All staff will be educated on the QMP on **12/30/2025.**

---

2. How the Agency Identified Other Clients Potentially Affected

The Administrator reviewed all active and recently discharged client records from the past 12 months to determine whether any client care issues were missed or unmonitored due to a lack

of a QMP.
No immediate care concerns were identified; however, performance data lacking in the absence of a QMP is now being collected and reviewed under the new program.

---

3. Systemic Changes to Prevent Recurrence

To ensure recurrence does not occur, the governing body has implemented the following systemic changes:

- Established a standing **Quality Management Committee** chaired by the Administrator.
- Created required QMP forms, logs, performance indicators, and corrective action templates.
- Implemented quarterly governing body/QMP meetings with documented minutes and action plans.
- Added QMP oversight responsibilities to the Administrator's job description.
- Revised agency policy manual to include the newly approved QMP.
- Required new hires to complete QMP training during orientation.

These changes embed the QMP as a permanent, documented governance function.

---

4. How the Agency Will Monitor Ongoing Compliance

The governing body will evaluate QMP compliance using the following methods:

- Monthly audits of QMP documentation for the first 6 months, then quarterly thereafter.
- Quarterly QMP Committee meetings with documented minutes, reviewed and signed by the governing body.
- Annual Agency-Wide Quality Evaluation is conducted every **month** with a written report.
- QMP compliance will be a standing item on the governing body agenda for continuous review.
- A corrective action plan will be immediately initiated for any QMP component found out of compliance.

The Administrator will report QMP monitoring results to the governing body each quarter.

---

5. Completion Date 12/30/2025

Tag# 1908: Grievance Procedures – External Grievance Resources & Client Rights Notification

Deficient Practice:

The agency failed to ensure that the grievance policy included the required State Survey Agency information, and failed to ensure clients received complete external grievance resources—including names, phone numbers, addresses, and the Wyoming State Home Health Hotline—in their admission packets.

---

1. Corrective Action Taken for the Identified Issue

- On **12/15/2025**, the grievance policy titled *"Grievance Procedure for Home Health and Waiver Service"* was revised to include:
  - The **State Survey Agency** contact information
  - All required **external grievance resources**, including names, phone numbers, and mailing addresses
  - The **Wyoming State Home Health Hotline** number
- The admission packet was updated to include a standardized **External Grievance Resource Page** containing all required information.
- We will have begun getting all current clients the corrected grievance materials on **12/01/2025** with documented receipt placed in their records.

---

2. How the Agency Identified Other Clients Potentially Affected

The Administrator audited all active client admission packets from the previous 12 months to determine if incomplete grievance materials were provided.
All clients missing required external grievance information were/will be contacted and mailed or hand-delivered the updated resource sheet by 12/30/25.

Documentation of receipt was entered into each applicable client chart.

---

3. Systemic Changes to Prevent Recurrence

To prevent recurrence, the agency implemented the following systemic changes:

A. Revised Admission Packet Process

- Created a **Grievance Resource Checklist** that must be signed by the admitting staff member and included in every admission packet.
- Standardized the **External Grievance Resource Sheet** and incorporated it as a mandatory packet component.

B. Policy Enhancements

- Updated the grievance policy to clearly identify:
  - All external grievance channels
  - Required documentation components
  - Hotline reporting procedures
  - Timeframes for external complaint referrals
- Added an annual policy review requirement by the governing body.

C. Staff Training

- All administrative and field staff responsible for admissions will have received updated training on grievance procedures and client rights on **12/30/2025.**

D. Integration Into the Quality Management Program (QMP)

- A new QMP indicator was added to review grievance materials for:
  - Completeness
  - Accuracy
  - Timely disclosure to clients

---

4. How Compliance Will Be Monitored

The Administrator or designee will conduct:

- **Monthly audits for three (3) consecutive months** of randomly chosen admission packets to verify:
  - The grievance policy is current
  - The External Grievance Resource Sheet is present
  - The Wyoming State Home Health Hotline is included
  - The checklist is properly completed
- After 3 months, audits will occur **quarterly**.
- Audit findings will be reviewed during **QMP meetings** and **Governing Body meetings**, with corrective actions documented in the minutes.
- Any missing or outdated grievance information will trigger immediate re-training of the staff involved.

Documentation of these audits will be retained for review by the Licensing Division and State Survey Agency.

---

5. Completion Date 12/30/2025

Tag:1908 Corrective Action Taken for the Clients Identified

- All seven identified clients were contacted beginning **11/15/25** and provided a written copy of their **Client Rights**, including:
  - Care planning participation
  - Choice of caregivers
  - Advance notice of schedule changes and care changes
  - Financial responsibility notice
  - Home Health Hotline number
- Each client's care plan was reviewed with them, updated according to their wishes, and documentation was added to each medical record.
- Caregiver assignment information was discussed and updated according to client preference.
- All staff involved in the care of these seven clients were re-educated on client rights requirements on 11/20/25 and will continue through 12/30/2025.

---

2. How the Agency Identified Other Clients Who Could Be Affected

- The Administrator performed a full audit of **100% of active and discharged client records from the past 12 months** to determine whether:
  - Client rights were provided at admission
  - The hotline number was given
  - Care plan participation was documented
  - Caregiver choice or scheduling preferences were noted
- Clients with incomplete documentation were immediately provided written rights information and given an opportunity to participate in updating their care plan.
- All charts are being corrected as needed with a completion goal of 12/30/2025.

---

3. Systemic Changes Implemented to Prevent Recurrence

The governing body adopted a comprehensive **Client Rights Policy** that includes:

je

A. Policy Requirements Added

- Written rights provided to clients at admission with signed acknowledgement.
- Documentation of client participation in developing and modifying the care plan.
- Procedures for informing clients of names and roles of caregivers.
- A standard process for informing clients of any schedule or provider changes in advance.
- Requirement to provide the **Home Health Hotline number** in the admission packet and on the agency website.
- Documentation requirements for all rights-related communication.

B. Forms and Packet Updates

- Admission packet updated to include:
  - Client Rights Statement
  - Home Health Hotline number
  - Care Plan Participation Form
  - Caregiver Preference Form
- New Hire Orientation updated to include mandatory Client Rights training.

C. Training

- All employees received education on client rights, documentation expectations, and communication procedures as of **12/01/2025.**
- Annual training added to agency training policy as well as including this training in onboarding of new employees.

---

4. Monitoring to Ensure Ongoing Compliance

The Administrator or designee will:

- Conduct **monthly audits** for 6 months of 10% of all active client records verifying:
  - Signed client rights receipts
  - Care plan participation documentation
  - Caregiver choice acknowledgement
  - Hotline number included in packet
- After 6 months, audits will occur **quarterly**.
- Audit findings will be reviewed at every **Quarterly QMP Meeting** and **Governing Body Meeting** with documented minutes.
- Any failure to follow policy will result in immediate staff retraining and corrective action.

Monitoring will continue indefinitely as part of the agency's Quality Management Program.

pe

5. Completion Date 12/30/2025

Tag:S1911-Advanced Directives;

We have added an Advance Directive policy/information sheet to our intake packet for clients, When it is available we will obtain it through medical records and honor the wishes the client and doctor have decided on. The facility is asking all current clients if they have advanced directives. If so, a copy will be placed in the chart.

S1912- Corrective Action Taken for the Clients Identified

A. Home Health Hotline

- The admission packet was immediately updated on **11/05/2025** to include the required **Home Health Hotline number**.
- All seven clients currently receiving services were contacted and provided the corrected packet with hotline information. Documentation was added to their medical records.

B. Plans of Care – Clients #1 and #2

- Comprehensive, individualized **Plans of Care (POC)** were developed for Clients #1 and #2,3,7 on **11/18/2025 OTHER CLIENTS HAVE BEEN DISCHARGED FROM PRACTICE.**
- Missing required components were completed, including:
  - Date of birth
  - Diagnosis
  - Allergies
  - Medication list
  - Insurance information
  - Advance directives
  - Client goals
  - Precautions
  - DME

- Tasks and frequencies for authorized services
- A care plan review meeting was held with each client to update care goals and confirm the services they prefer and need.
- Staff providing care to Clients #1 and #2 were re-educated on the new Plans of Care.

---

2. How the Agency Identified Other Clients Potentially Affected

- The Administrator reviewed **100% of active and discharged client records from the previous 12 months** to determine whether any additional clients lacked a compliant Plan of Care or hotline information.
- Any client lacking documentation received:
  - An updated admission packet with hotline number,
  - A comprehensive Plan of Care, and
  - Documentation showing participation in the care planning process.
- All corrections will be completed by **12/30/2025**.

---

3. Systemic Changes Implemented to Prevent Recurrence

A. Plan of Care Policy Implementation

The Governing Body approved a comprehensive **Plan of Care Policy** that includes:

- Requirements for the development of an individualized POC for EACH client.
- Required clinical elements: DOB, diagnosis, allergies, medications, goals, DME, precautions, etc.
- Required service elements: frequency, tasks, duration, and provider responsibilities.
- Required documentation of client participation in care planning.
- Annual review and revision process or sooner with any change in condition.

B. Admission Packet Revision

- Updated admission packet now includes:
  - Client Rights statement
  - Home Health Hotline number
  - Care Plan Participation form
  - Advance Directives information
- New packets are being printed and implemented completion planned 12/30/2025

C. Staff Training

- All staff, including CNAs, caregivers, and administrative staff, were re-trained on completed and will be trained on completed POC as they are completed before 12/30/2025:
  - Client rights
  - Plan of Care development
  - Documentation requirements
  - Use of new forms
  - Hotline requirements
- Training to be completed by **(12-30-2025)** and documented in personnel files.

D. Forms and Tools Created

- Plan of Care template (HHA-compliant)
- Caregiver task list form
- Client Rights acknowledgment
- Advance Directives acknowledgment
- Hotline information page
- Monthly POC audit tool

E. Integration into Quality Management Program (QMP)

- POC compliance and hotline verification added as standing components of the QMP.
- Findings will be reviewed during quarterly QMP and Governing Body meetings.

---

4. How the Agency Will Monitor Ongoing Compliance

The Administrator or designee will perform:

Monthly Monitoring (first 6 months):

- Audit of **10% of active client records** to verify:
  - Presence of a complete Plan of Care
  - Required clinical and administrative elements included
  - Documentation of client participation
  - Hotline information present in the admission packet
- Any missing items will be corrected immediately and staff responsible will be re-educated.

Quarterly Monitoring (ongoing after 6 months):

- Quarterly QMP audits of all new admissions for POC completion within 48 hours of service authorization.
- Findings reviewed in Governing Body meetings with written minutes.

- Corrective actions implemented as needed.

Annual Review

- Annual agency-wide evaluation of forms, policies, training, and documentation related to Plans of Care and client rights.

Monitoring will continue indefinitely.

---

5. Completion Date 12/30/2025

Tag: S1914 Ch 9 Sec 6 (a)-(d) Home Health Aide
Wyoming state board of nursing stated we needed to email the additional training HHA sheets to them directly, however this was determined to be incorrect and we then had the CNA access their portals and upload the proper documentation as required as of 12/01/2025. We will ensure this process occurs within the first 5 days of on the job training moving forward.
Nurses will ensure observation of CNA each 30 days occurs the first week of every month. Beginning 12/01/2025.
Plan of care information will be accessible to the CNA through the electronic portal each visit for the CNA to complete.

Tag S1914 – Ch. 9 Sec. 6(a)–(d) Home Health Aide Requirements
(a) CNA competency training
(b) 30-day skilled supervision
(c) Personal care delivery
(d) 60-day written instructions

S1914:Related Deficiencies: Missed Visits, Scheduling, Staff Responsibilities, Lack of Plan of Care

1. Corrective Action Taken for Clients Identified and CNAs Involved

A. Immediate Correction of CNA Competence Deficiencies

- On **11/10/2025**, all four CNAs (CNA #1, #2, #3, #4) were removed from client scheduling until competency validation was completed. Two of which did not attempt to complete the training and abandoned their positions.
- Each CNA underwent:
  - Full home-setting competency evaluation
  - Skills return-demonstration

  - Personal care task validation checklist
  - Review of infection control, safety, communication, and client rights
- Completed competency packets were placed in each CNA's personnel file.

B. Supervisory Visits Initiated

- Supervisory RN completed immediate supervisory visits for all clients receiving personal care or skilled services beginning **11/11/2025**
- Documentation of supervisory findings and care plan updates was added to each client's record.

C. Written Aide Instructions Provided

- Aides were given written, client-specific instructions for these specific clients and continue to receive through electronic records POC instructions based on the individualized Plan of Care.
- Instructions were reviewed and acknowledged by each CNA.

D. Missed Visits and Care Failures Corrected

- Clients who experienced missed or late visits were attempted to be contacted the same day and offered make-up care when appropriate.
- Backup scheduling staff were assigned for affected clients if able/desired.
- Aides involved in missed visits were counseled and re-educated on agency policy.

---

2. How the Agency Identified Other Clients Potentially Affected

- The Administrator reviewed **100% of active and discharged client records for the past 12 months** for:
  - Missing CNA competency documentation
  - Missing supervisory visits
  - Missing 60-day aide instructions
  - Missed or inconsistent personal care visits
  - Documentation of client complaints related to aide performance
- Clients missing documentation received:
  - Immediate supervisory visits
  - Written aide instructions
  - Updated Plans of Care
  - Corrections to scheduling and staffing assignments

All corrections will be completed by **12/30/2025**.

3. Systemic Changes Implemented to Prevent Recurrence

A. CNA Competency Training Program Implemented

The Governing Body approved a new **Home Health Aide Competency Program**, including:

- Written and skills-based competency checklists
- Required home-setting training modules yearly.
- Annual competency evaluation
- Documentation stored in the personnel file
- Immediate removal from client care if competency lapses are identified

B. Supervisory Visit Policy Implemented

A new policy requires:

- RN or LPN supervisory visits **every 30 days** for all clients receiving personal care who also require skilled oversight
- Supervisory visit documentation placed in the client record
- Immediate follow-up after missed or late visits

C. Written Aide Instructions Standardized

A standardized **60-Day Aide Instruction Form** was created and includes/not limited to off of POC:

- Client-specific tasks
- Safety precautions
- Goals and preferences
- DME usage
- Skin integrity reminders
- Nutrition, hydration, ambulation, and transfer guidance

Supervisory nurses must update and sign the form at least every **60 days** or sooner when condition changes occur.

D. Missed Visit Protocol Adopted

A new Missed Visit Procedure requires:

- Aide must notify agency immediately if unable to report
- Agency must notify client promptly and offer alternate staff
- Supervisor follow-up after ANY missed visit

- Documentation in the missed visit log and client record
- Monthly review by Administrator

E. Scheduling & Staffing System Implemented

- Detailed schedules now include:
  - Assigned aide
  - Day and time of each visit
  - Estimated length of visit
  - Backup staff assignment
- Clients receive written schedules and acknowledge preferences.
- Staff must clock in/out using the electronic scheduling system.

F. Staff Training

On 11/30/2025, all CNAs, backup aides, and administrative staff were trained on:

- CNA competency requirements
- Supervisory visit procedures
- Written aide instructions
- Missed visit protocols
- Client rights related to reliable services
- Documentation standards

Training added to orientation and annual training.

G. Integration into the Quality Management Program (QMP)

- CNA competency and supervisory compliance added as QMP indicators.
- Missed visits, aide no-shows, and corrective actions tracked monthly.
- QMP Committee reviews findings quarterly with Governing Body oversight.

---

4. How the Agency Will Monitor Ongoing Compliance

Monthly Monitoring (First 6 Months)

Administrator or RN Supervisor will audit:

- 10% of client records for supervisory visits
- 10% of aide instructions for completeness
- All missed visit logs
- CNA competencies for currency
- Scheduling accuracy and timeliness

Immediate corrective actions will be taken for any deficiencies.

Quarterly Monitoring (After 6 Months)

The QMP Committee will review:

- CNA competency compliance
- Supervisory visit frequency
- Aide instruction documentation
- Missed visit patterns and trends
- Client complaints related to aide services

Minutes will be documented and presented to the Governing Body.

Annual Evaluation

An annual agency-wide audit will assess:

- Continuity and reliability of aide services
- Compliance with 30-day and 60-day requirements
- Personnel file accuracy
- Training effectiveness
- Policy implementation

Monitoring continues indefinitely.

---

5. Completion Date-12/30/2025

S1917:Corrective Action Taken for Clients Identified

A. Missed Visits and Inconsistent Scheduling

- Immediately upon notification on **11/06/2025**, the agency contacted Clients #1, #3, and #4 to apologize for missed or late visits and attempt to arrange make-up care as appropriate. OTHER CLIENTS HAVE BEEN DISCHARGED OR APPT. WAS FULFILLED.
- Temporary staff coverage was assigned to ensure continuity of care until permanent schedules were re-established.

- All assigned aides involved in the missed visits were counseled and re-educated on attendance, reporting requirements, and agency policy.

B. Written Homemaker Service Plans

- For Clients #1, #3, #4, were created, individualized service plans were developed on **11/18/2025-12/01/2025**. OTHER CLIENTS HAVE BEEN DISCHARGED
- Each plan includes:
  - Required tasks
  - Frequency and duration
  - Client-specific needs, preferences, and safety considerations
  - Documentation expectations for staff
- These were reviewed with each client, and documentation was added to their medical records.

C. Supervisory Oversight

- Supervisory visits for Clients #1,3,4 were conducted by the supervising professional.
- Records were updated to reflect assessment of services, staff performance, and client satisfaction.

---

2. How the Agency Identified Other Clients Potentially Affected

- The Administrator reviewed **100% of all active and discharged clients within the past 12 months** to determine whether:
  - Required homemaker service plans were missing
  - Personal care schedules were inconsistent or undocumented
  - Missed visits had occurred without notification
  - Supervisory visits were overdue
- For any client missing a service plan, supervisory visit, or structured schedule:
  - A written service plan was created
  - Supervisory visits were completed
  - Schedules were set with the client
  - Documentation was entered into the medical record

All corrections will be completed by **12/30/2025**

---

3. Systemic Changes Implemented to Prevent Recurrence

A. Implementation of a Homemaker & Personal Care Service Plan Policy

A new policy was approved by the Governing Body on **12/01/2025** requiring:

- A written homemaker service plan for every client receiving such services
- Task-specific, client-specific instructions
- Scheduling documentation including staff assignment, days, and times
- Supervisor approval prior to implementation
- Annual review or sooner if condition or needs change

B. Scheduling Protocol Implementation

- A standardized scheduling system was created for all personal care and homemaker clients.
- Each client now has:
  - A structured weekly schedule
  - Assigned primary and backup aides
  - Documented visit times
  - A notification system for schedule changes

C. Missed Visit Procedure

A new **Missed Visit Protocol** was implemented that requires:

- Immediate notification to the agency by aides if they cannot attend a visit
- Immediate notification to clients if substitutions or changes occur
- Documentation of missed visits and corrective actions
- Administrator review of all missed visit incidents

D. Staff Training

On **11/30/2025** all aides, CNAs, and administrative staff were re-trained on:

- Timeliness and scheduling requirements
- Notification and reporting expectations
- Written homemaker service plan implementation
- Supervisory visit expectations
- Documentation standards
- Client rights related to reliable scheduling and consistent caregivers

Training was added to new-hire orientation and annual competency requirements.

E. Supervisory Visit Procedure

A new supervision policy requires:

- Supervisory visits at least every 60 days or sooner if concerns arise
- Documentation of aide performance

- Verification of service completion and client satisfaction
- Updates to service plans as needed

F. Integration Into Quality Management Program (QMP)

The QMP now includes:

- Monthly audits of homemaker plans
- Monthly tracking of missed visits
- Staff compliance performance indicators
- Quarterly reports to the Governing Body
- Corrective actions and follow-ups documented in QMP minutes

---

4. How the Agency Will Monitor Ongoing Compliance

Monthly Monitoring (First 6 Months)

The Administrator or supervising professional will audit:

- 10% of records for complete homemaker service plans
- All missed visit logs
- Documentation of aide arrival and departure times
- Updated schedules in client records
- Supervisory visits completed on schedule

Any deficiencies found will be corrected immediately, with staff retraining as needed.

Quarterly Monitoring (After 6 Months)

- QMP committee will review:
  - Homemaker service plan compliance
  - Missed visit trends
  - Scheduling adherence
  - Supervisory visit compliance
  - Staff performance issues

Results will be documented in Governing Body minutes.

Annual Review

The Governing Body will conduct a full annual evaluation of:

- Service plans

- Missed visit patterns
- Staff adherence to scheduling
- Supervisory visit completion
- Policies and procedures
- Staff training effectiveness

Monitoring will continue indefinitely as part of QMP.

---

5. Completion Date 12/30/2025

Tag:1921 Ch. 9 Sec. 8(a)–(c) – Client Records

---

1. Corrective Action Taken for the Identified Client (#7)

- On **11/30/2025**, the Administrator completed a review of all available documentation for Client #7 and reconstructed the client record to the extent possible using:
  - Staff visit notes
  - Scheduling documentation
  - Any available communication and service logs
- The reconstructed record was placed into the client's official file per retention requirements.
- Staff responsible for intake, assessment, and care planning will be re-educated on proper filing and record retention procedures prior to **12/30/2025**

---

2. How the Agency Identified Other Clients Potentially Affected

- The Administrator conducted a complete audit of **100% of active and discharged client records within the past 12 months** to determine whether any additional assessment or plan of care documents were missing.
- Any incomplete record was immediately corrected and brought into compliance, with missing documents located, scanned, and secured.
- No other missing assessments or plans of care were identified (or **insert corrected findings**, if applicable).

---

3. Systemic Changes Implemented to Prevent Recurrence

A. Record Retention & Safeguarding Policy Revision

The Governing Body approved an updated **Record Retention and Safeguarding Policy** which includes:

- Procedures for uploading, scanning, and filing client documents the same day they are created.
- Requirements for maintaining complete records for **each client receiving services**, including:
  - Assessment
  - Plan of Care
  - Service logs
  - Admission documents
  - Client rights
  - Advance directives
  - Supervisory notes
- A centralized tracking system ensures all required documents are present at admission and discharge.
- Protections to safeguard records from loss, damage, or unauthorized use.

B. Staff Training

On **11/25/25** all clinical, administrative, and intake staff were re-trained on:

- Required contents of every client record
- Document retention requirements (6 years)
- Proper safeguarding and storage procedures
- Immediate reporting requirements when documents cannot be located

Training was added to new-hire onboarding and annual competency requirements.

C. Implementation of a Record Completion Checklist

- A standardized **Client Record Completion Checklist** was implemented to ensure all required documents are present before:
  - Start of care
  - Each supervisory visit
  - Discharge
- All checklists must be signed by a supervising professional and filed in the record.

D. Electronic/Physical Filing System Improvements

- Records were reorganized to ensure consistent filing structure.
- Scanning procedures were updated to ensure electronic copies are secured and backed up.
- Only authorized personnel may modify, scan, or file client documents.

E. Integration Into Quality Management Program (QMP)

Record completeness and retention compliance were added to QMP indicators.
Quarterly Governing Body meetings will include review and documentation of record audits and trends.

---

4. How the Agency Will Monitor Ongoing Compliance

Monthly Monitoring (First 6 Months)

The Administrator or designee will audit **10% of active and discharged client records** each month to verify:

- Assessments present
- Plans of Care present
- Signing and dating requirements met
- Documents filed in correct locations
- Records safeguarded and accessible only to authorized staff

Any missing documentation will be corrected immediately and responsible staff retrained.

Quarterly Monitoring (After 6 Months)

Quarterly audits through the QMP will assess:

- Record completeness
- Safeguarding practices
- Retention compliance
- Filing and documentation accuracy

Results will be reported to the Governing Body and corrective action plans implemented as needed.

Annual Review

The agency will conduct a full annual records review assessing:

- Retention system effectiveness
- Compliance with safeguarding requirements
- Staff performance
- Policy adherence and updates

Monitoring will continue indefinitely.

5. Completion Date

12/30/2025