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 _____	R-C 02/18/2026

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. A revisit survey was conducted on 1/9/26 through 2/18/26 for all previous deficiencies cited on 11/5/25. All deficiencies have been corrected, and no new noncompliance was found. The facility is in compliance with all regulations surveyed.	{S 000}		