STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 537079	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cowboy Cares Home Health	**39806 Business Loop 80, Ste 2 , Lyman, Wyoming, 82937**

(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
G0000	INITIAL COMMENTS A complaint survey was conducted by Healthcare Licensing and Surveys from 2/24/26 to 2/26/26. The survey was prompted by complaint intake #2710939.	G0000		
G0800	Services provided by HH aide CFR(s): 484.80(g)(2) A home health aide provides services that are: (i) Ordered by the physician or allowed practitioner; (ii) Included in the plan of care; (iii) Permitted to be performed under state law; and (iv) Consistent with the home health aide training. This ELEMENT is NOT MET as evidenced by: Based on medical record review, staff interview, and policy review, the agency failed to provide services as directed in the plan of care for 1 of 5 sample clients (#3). The findings were: 1.Review of the Plan of Care for client #3 dated 12/29/25 to 2/26/26 showed the Home Health Aide (HHA) patient-specific orders for discipline and treatments: Frequency and Duration: 6 hours weekly times 9 weeks. Review of the HHA visit notes showed the last home visit was done on 12/31/25. 2. Interview with the DON (Director of Nursing) on 2/25/26 at 3:46 PM revealed the agency failed to get the discontinue order for the HHA services for client #3. She stated the agency stopped the visits for the HHA services. 3. Review of the policy "Home Health Aide Service" hand delivered on 2/25/26 at 2:33 PM by the DON showed "...1. b. A Home Health Aide provides services that are: i. Ordered by the physician; ii. Included in the plan of care; iii. Permitted to be performed under state law; and iv. Consistent with the home health aide training..."	G0800		

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	537079	A. BUILDING B. WING	**02/26/2026**

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G0800		G0800		