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

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 537026	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Johnson County Healthcare Center Home Health Agency	497 West Lott , Buffalo, Wyoming, 82834

(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
E0000	Initial Comments An Emergency Preparedness survey was conducted by Healthcare Licensing and Surveys on 3/26/26. Based upon the findings of the survey, it was determined that no deficiencies were identified pertaining to the Emergency Preparedness Rule.	E0000		
G0000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 3/23/26 to 3/26/26. The following common abbreviation are used throughout this document: CNA: Certified Nursing Assistant POC: Plan of Care RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	G0000		
G0414	HHA administrator contact information CFR(s): 484.50(a)(1)(ii) (ii) Contact information for the HHA administrator, including the administrator's name, business address, and business phone number in order to receive complaints. This ELEMENT is NOT MET as evidenced by: Based on observation, review of the patient handbook, and staff interview the agency failed to ensure the correct business address was provided for clients to contact the administrator. The findings were: 1. Observation on 3/23/26 at 1:40 PM revealed the building of the Home Health Agency failed to show it was the location of the Home Health Agency and the administrator. There was no signage showing the agency name, nor the hours of business.	G0414		

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
Sh Pare Rn	Director/Administrator	4.16.26

5/11 Bk POC accepted talked w Steve Catherine Shadden RN

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30414	Continued from page 1 2. Review of the "Home Health Patient & Family Handbook" showed the address of the hospital and not the location of the Home Health Agency and the Home Health Agency administrator. 2. Interview with the administrator on 3/23/26 at 2:25 PM confirmed the building was not identified as the Home Health Agency, and was not the location given to the clients to contact the administrator.	G0414		
30514	RN performs assessment CFR(s): 484.55(a)(1) A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status. The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician or allowed practitioner - ordered start of care date. This ELEMENT is NOT MET as evidenced by: Based on client medical record review, staff interview, and policy review the agency failed to ensure the initial assessment visit was held either within 48 hours of referral, or on the physician or allowed practitioner ordered start of care date for 2 of 7 clients (#3, #6). The findings were: 1. Review of the medical records for client #3 showed the physician ordered the Start of Care (SOC) on 3/12/26. The agency initial assessment was done on 3/17/26 showing the SOC was 5 days after the ordered date. Further, review showed there was no order by the physician for the delay of services. 2. Review of the medical records for client #6 showed the physician ordered the SOC on 2/26/26. The agency's initial assessment was completed on 3/2/26, which showed the SOC was 4 days after the ordered date. Further review showed there was no order by the physician for the delay of services 3. Interview with the administrator on 3/24/26 at 2 PM revealed the agency did not get the physician order for the delay of services. He stated the agency did delay the SOC. 4. Review of policy "Acceptance of Patients HH/Hospice"	G0514		

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G0514	Continued from page 2 hand delivered by the administrator on 3/25/26 at 12:20 PM showed "...Responsibilities...Registered Nurse and/or Qualified Therapist (home Health) Perform the initial assessment to determine home health eligibility, service needs, and whether the agency can meet the patient's needs in the home environment." The policy failed to include the need for the assessment to be within 48 hours, or the need for the physician order for the delay in SOC.	G0514		
G0682	Infection Prevention CFR(s): 484.70(a) Standard: Infection Prevention. The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases. This STANDARD is NOT MET as evidenced by: Based on observation, staff interview, and policy and procedure review, the agency failed to ensure infection prevention guidelines for wound care were followed during 2 of 3 client home visits (#2, #3). The findings were: 1. Observation during the home visit for client #2 on 3/25/26 at 9 AM showed RN #1 failed to do hand hygiene prior to donning gloves. She placed the barrier under the client's legs, then pulled supplies out of her bag. She cleaned the right 2nd toe, then got a dressing out of a storage bag. She cleaned the right shin and left shin. She then went through three different supply bags (still wearing the same gloves) looking for different supplies. She pulled a pair of scissors from her work bag, cut optifoam dressing, then placed the dressing on the 2nd right toe. At this point she doffed her gloves and performed hand hygiene. 2. Observation during the home visit for client #3 on 3/24/26 at 11 AM with RN #1 showed the nurse failed to do hand hygiene prior to donning gloves. She placed a barrier down under the client left leg and donned gloves. She pulled her scissors out of her work bag and cut off the old dressing. The wound had sutures and staples still in place from a great toe amputation. The nurse searched through a supply bag for supplies. She went out to her truck and came in and doffed gloves and performed hand hygiene. She did multiple other tasks such as taking vitals, taking photographs, documenting on her laptop. She then donned gloves, cleaned the	G0682		

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0682	Continued from page 3 wound, opened dressing packets and cut dressings. She placed the new dressing over the wound and dressed the wound. At that point she doffed her gloves. 3. Interview with RN #1 on 3/25/26 at 10:20 AM revealed that it was her normal routine when doing wound care. 4. Interview with the administrator on 3/25/26 at 4:05 PM revealed it was the expectation for staff to perform "hand hygiene, don gloves, do the dirty, then doff gloves. The staff would then perform hand hygiene don new gloves, and dress the wound, doff gloves, and perform hand hygiene. 5. Review of the policy "Wound Assessment & Documentation" hand delivered on 3/26/26 at 9 AM by the administrator showed "…6. Infection Control Principles Perform hand hygiene before and after wound care…" 6. Review of the policy "Hand Hygiene" hand delivered on 3/26/26 at 9 AM by the administrator showed "…Procedures Hand Hygiene Indications…When moving from a dirty procedure to a clean procedure…Before donning any personal protective equipment (PPE) and after doffing any PPE…Before and after contact with non-intact skin…Glove Use…Remove gloves and perform hand hygiene at the appropriate indication (e.g., after exposure to body fluids and before a clean procedure) …"	G0682		
0808	Onsite supervisory visit every 14 days CFR(s): 484.80(h)(1)(i) (1)(i) If home health aide services are provided to a patient who is receiving skilled nursing, physical or occupational therapy, or speech language pathology services— (A) A registered nurse or other appropriate skilled professional who is familiar with the patient, the patient's plan of care, and the written patient care instructions described in paragraph (g) of this section, must complete a supervisory assessment of the aide services being provided no less frequently than every 14 days; and (B) The home health aide does not need to be present during the supervisory	G0808		

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G0808	Continued from page 4 assessment described in paragraph (h)(1)(i)(A) of this section. This ELEMENT is NOT MET as evidenced by: Based on medical record review and staff interview the agency failed to ensure supervisory visits were provided in no less then every 14 days for 2 of 7 clients reviewed (#1, #7). The findings were: 1. Review of the plan of care for client #1 showed the certification period of 2/7/26 through 4/7/26 the skilled nursing frequency was once every 60 days, and the CNA frequency was 3 times a week. Further review showed no supervisory visits had been completed between 2/7/26 through 3/11/26 (32 days). 2. Review of the plan of care for client #7 showed a certification period from 1/24/26 through 3/24/26 and the skilled nurse frequency was 1 time a week, and the CNA frequency was 2 times a week. Further review showed the CNA went 30 days without a supervisory visit (1/25/26 - 2/25/26). Then went 16 days without a supervisory visit (2/26/26 - 3/13/26). 3. Interview with the administrator on 3/25/26 at 4:05 PM revealed the supervisory visits on the 2 clients were not done every 14 days, and confirmed they were missed. 4. Review of the policy titled "Home Health / Hospice Aid Training, Assignment, Supervision and Documentation Guidelines" n.d. hand delivered on 3/24/26 at 3:20 PM by the administrator showed "...5. Aids are Supervised by an RN or other qualified professional in accordance with federal hospice and home health conditions of participation, Wyoming requirements, and applicable payer expectations..."	G0808		

Tag G0414 | CFR 484.50(a)(1)(ii) | HHA Administrator Contact Information

1. Corrective Action for Affected Clients

The patient and family handbook was corrected to reflect the accurate business address and administrator contact information for Johnson County Healthcare Center Home Health Agency (497 West Lott, Buffalo, WY 82834). This correction was completed on 03/24/2026 prior to the conclusion of the survey. All current active clients will receive the updated handbook by **05/1/2026**.

2. Identification of Other Potentially Affected Clients

All current active client records were reviewed to identify any client who received a handbook containing incorrect administrator contact information. All affected clients will receive the corrected handbook no later than **05/1/2026**.

3. Systemic Changes to Prevent Recurrence

Signage identifying JCCHHA including the administrator's title, business address (497 West Lott, Buffalo, WY 82834), and business phone number has been posted in the patient registration area at the main lobby entrance.

Completion Date: 04/18/2026

4. Ongoing Monitoring

The Administrator will verify signage is current and visible during quarterly QAPI review. Any identified lapse will be corrected within 5 business days.

Responsible Party: Administrator
Completion Date: 03/24/2026 (handbook correction completed); **05/1/2026** (all remaining actions)

Tag G0514 | CFR 484.55(a)(1) | RN Performs Initial Assessment

1. Corrective Action for Affected Clients

Clients **(#3, #6)** identified in the survey had received their initial RN assessments and were admitted to care. Both records were reviewed, and the responsible clinician received individualized education and documented counseling regarding the requirement that the initial RN assessment be completed within 48 hours of referral or physician-ordered Start of Care (SOC) date. The clinician was further educated that any SOC delay beyond 48 hours requires a physician order prior to scheduling the revised SOC date.

Completion Date: 03/28/2026 **(records reviewed), 04/18/2026 (education provided)**

2. Identification of Other Potentially Affected Clients

The Administrator will conduct a retrospective review of all active client records for the previous 90 days to identify any case where the SOC date exceeded 48 hours from the referral or physician-ordered SOC date without a corresponding physician order on file authorizing the delay. Any identified records will be flagged and the responsible clinician notified for correction.

Completion Date: **05/1/2026**

3. Systemic Changes to Prevent Recurrence

The agency admission policy "Acceptance of Patients HH/Hospice" has been revised to explicitly require: (a) the initial RN assessment be completed within 48 hours of referral or physician-ordered SOC date; and (b) any delay beyond 48 hours be authorized by a physician order documenting the reason for and approval of the revised SOC date prior to scheduling. All clinical and scheduling staff will receive education on the updated policy with documented acknowledgment.
Completion Date: Policy update 03/28/2026; Clinician education 04/18/2026

4. Ongoing Monitoring

The Administrator will review new admission SOC dates monthly for the first 90 days following POC submission to verify compliance within 48 hours or the presence of a physician order authorizing any delay. Findings will be reported at the quarterly QAPI meeting. Any identified deficiency will result in clinician follow-up and corrective action within 5 business days.

Responsible Party: Administrator
Completion Date: 03/28/2026 (clinician counseling completed, policy updated); 04/18/2026 (clinician education) **05/1/2026** (all remaining actions)

Tag G0682 | CFR 484.70(a) | Infection Prevention

1. Corrective Action for Affected Clients

Clients (#2, #3) identified in the survey were assessed for signs of wound infection or adverse outcomes related to the observed infection prevention lapses. No adverse outcomes were identified. The clinical staff member involved received individualized education and competency review regarding hand hygiene protocols, proper glove use, and standard precautions during wound care, with documented acknowledgment of retraining.

Completion Date: 03/28/2026

2. Identification of Other Potentially Affected Clients

All active clients receiving wound care services were reviewed for signs of infection or adverse outcomes. No signs of infection or adverse outcomes were identified.

Completion Date: 03/28/2026

3. Systemic Changes to Prevent Recurrence

All clinical staff will receive mandatory competency-based education on hand hygiene, standard precautions, and wound care infection control protocols, with documented return demonstration and signed acknowledgment. Annual wound care competency demonstration will be incorporated into the agency's existing competency program.

Completion Date: **05/1/2026**

4. Ongoing Monitoring

The Administrator will conduct direct observation of wound care technique during supervisory visits for all clinical staff monthly for the first 90 days following POC submission. Findings will be reported at the quarterly QAPI meeting. Any identified deficiency will result in immediate retraining within 5 business days.

Responsible Party: Administrator
Completion Date: 03/28/2026 (affected client review and clinician retraining completed); 05/1/2026 (all-staff competency education completed)

Tag G0808 | CFR 484.80(h)(1)(i) | Onsite Supervisory Visit Every 14 Days

1. Corrective Action for Affected Clients

Clients (#1, #7) identified in the survey were reviewed and their supervisory visit schedules were corrected to meet the requirement of no less than every 14 days. The Administrator reviewed both records, confirmed the gaps in supervisory visit completion, and brought both clients into compliance with the required visit frequency.

Completion Date: 03/28/2026

2. Identification of Other Potentially Affected Clients

The Administrator will conduct a retrospective review of all active clients currently receiving CNA services to identify any case where supervisory visits were not completed within the required 14-day interval. Any identified gaps will be corrected immediately and the responsible clinician notified.

Completion Date: **04/21/2026**

3. Systemic Changes to Prevent Recurrence

The root cause of this deficiency was the absence of a scheduling and tracking system for CNA supervisory visit compliance. A manual tracking log will be implemented immediately for all active CNA patients documenting the required visit frequency, last supervisory visit date, and next visit due date. This log will be maintained until CNA supervisory visit tracking is fully operationalized within the agency's EMR system. All staff will receive education on the requirement that CNA supervisory visits be completed no less than every 14 days for all patients receiving both skilled and CNA services, with documented acknowledgment.

Completion Date: **04/21/2026**

4. Ongoing Monitoring

The Administrator will review the CNA supervisory visit tracking log monthly to verify all visits are occurring within required intervals. Findings will be reported at the quarterly QAPI meeting. Any identified gap will be corrected within 2 business days of identification.

Responsible Party: Administrator
Completion Date: 05/1/2026 (all remaining actions)