EPARTMENT OF HEALTH AND HUMAN SERVICES
ENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 537035	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Campbell County Health Home Health	901 W 2nd Street , Gillette, Wyoming, 82716

(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
:0000	Initial Comments An Emergency Preparedness survey was conducted by Healthcare Licensing and Surveys on 7/2/26. Based upon the findings of the survey, it was determined that no deficiencies were identified pertaining to the Emergency Preparedness Rule.	E0000	On 7/19/2025 Home Health went live with a new EMR system, as stated in deficiency. It took some time to get the file conversion in EPIC that submits the data to CMS worked out and this did result in late submissions. We have worked closely with the IT department of the new EMR on issues arising to correct them. In February 2026, we found that not all the patients were being included in the file that submits to CMS. We worked closely with IT so that we would get a warning message if a file was "unlocked" and therefore not included on the CMS data file. This did result in some late submissions in February 2026, after we had 2 months of zero late submissions prior to that. There have been no late submissions in the last 3 months of May, June and July to CMS since we have the processes worked out with our EMR company. As a quality assurance program, during the quality review process, the HH manager has created a spreadsheet on July 13, 2026 with each patient name. When an Oasis has been reviewed and marked for submission to CMS, the manager will verify the patient is included in the submission file created by the EMR. This will catch any missing patients prior to them being late submissions. This quality assurance process from the date of patients' admission to HH to the data submission to CMS will be done within 14 days from the SOC date. This will leave time to correct any rejected submissions prior to the 30-day time frame.	
30000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 6/29/26 through 7/2/26.	G0000		
30372	Encoding and transmitting OASIS CFR(s): 484.45(a) Standard: An HHA must encode and electronically transmit each completed OASIS assessment to the CMS system, regarding each beneficiary with respect to which information is required to be transmitted (as determined by the Secretary), within 30 days of completing the assessment of the beneficiary. This STANDARD is NOT MET as evidenced by: Based on review of the iQIES "HHA Error Summary by Agency" report, and staff interview, the agency failed to ensure timely OASIS assessment submission for 22 clients. The finding were: 1. Review of the iQIES "HHA Error Summary by Agency" report ran from 10/1/25 through 6/23/26, showed the agency had submitted 22 patient assessments which resulted in error code -3330. This indicated the assessment was submitted late. 2. Interview with the Home Health Manager on 7/1/26 at 9:30AM revealed the agency was unaware of the 22 late submissions, and was unable to produce the names of the 22 clients. She revealed the agency had changed computer systems and was having some issues getting the information submitted.	G0372		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that othe 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
[signature]	Manager	7/30/26

POC accepted. DOC 7/14/26. MSS left this Jennifer Brown on 7/31/26 @ 3:10p [signature]

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30574	Plan of care must include the following CFR(s): 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. This ELEMENT is NOT MET as evidenced by: Based on client medical record review, and staff interview, the agency failed to ensure a detailed, individualized plan of care for 7 of 7 sampled clients (#1, #2, #3, #4, #5, # 6, #7) reviewed. The findings were:	G0574	To address the deficiency of lack of individualized safety measures on care plans, we have created a new "care plan problem" called "Patient safety education". This was created on 7/1/2026. This new care plan problem allows the nurse to add patient specific interventions related to safety risks. The nurse will determine patient risk factors on admission and will add interventions to the care plan that are specific to that patient and that are visible to all clinicians doing home visits. Nurses were educated in a meeting on 7/14/2026 on the purpose and new process to add these to the care plan. All other clinicians have been educated to look at this on the care plan for patient specific safety factors. Manager does a chart audit on every admission chart within 2 days of admit. A quality assurance process began 7/14/2026 that the manager will audit all admission charts to assure individualized safety measures are added to each careplan. This is documented on a spreadsheet so that compliance will be monitored on an ongoing basis. Of the patients mentioned in the deficiency, four of them are now discharged from services. Patients #5, 1 and 2 have had the individualized	

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30574	Continued from page 2 1. Review of the care plan dated 1/6/26, and last updated on 1/22/26 showed client #3 was at risk for falls. Further review showed interventions included "...Instruct in home safety and fall prevention strategies - monitor patient / caregiver adherence to and mindfulness of fall prevention strategies..." 2. Review of the care plan dated 11/18/25, and last updated 11/26/25 showed client #4 was at risk for falls. Further review showed interventions included "...Instruct in home safety and fall prevention strategies - monitor patient / caregiver adherence to and mindfulness of fall prevention strategies..." 3. Review of the care plan dated 4/30/26, and last updated 5/11/26 showed client #5 was at risk for falls. Further review showed interventions included "...Instruct in home safety and fall prevention strategies - monitor patient / caregiver adherence to and mindfulness of fall prevention strategies..." 4. Review of the care plan dated 5/14/26 showed client #1 had diagnoses that included pressure ulcer of sacral region (stage 2), dementia, Down Syndrome, and epilepsy. Further review showed the client was a fall risk, and skin breakdown risk, Review of the safety measures failed to show seizure precautions, blood and body fluid precautions, and fall precautions. 5. Review of the care plan dated 5/29/26 showed client #2 had diagnoses that included pressure ulcer of right buttock (stage 2), cellulitis of left lower limb, acquired absence of right leg below knee, dependence on renal dialysis, type 2 Diabetes Mellitus with diabetic chronic kidney disease, and diabetic neuropathy. Further review showed the client was at risk for infections, used a blood glucose monitor, and was at risk for falls and skin breakdown. Review of the safety measures failed to show sharp precautions, blood and body fluid precautions, fall precautions, and hypo/hyperglycemia precautions. 6. Review of the care plan dated 5/23/26, and last updated 6/5/26 showed client #6 had diagnoses that included rectal abscess, rectal fistula, malignant neoplasm of rectum, brain, left lung, right lung, and right adrenal gland, generalized epilepsy, colostomy, and drug-induced polyneuropathy. Further review showed the client was at risk for falls, and had problems with deep wounds with moderate to heavy drainage, Review of the safety measures failed to show seizure precautions, blood and body fluid precautions, and fall precautions.	G0574	safety education section added to their care plans. The specific safety interventions include fall, aspiration, bleeding, oxygen, activity, seizure, risk for skin breakdown, diabetic, infection risk, and standard. More can be added as appropriate. Interventions include assessment and patient/caregiver education.	

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G0574	Continued from page 3 7. Review of the care plan dated 6/21/26, and last updated on 6/29/26 showed client #7 had diagnoses that included other specified sepsis, parainfluenza virus pneumonia, other toxic encephalopathy, chronic myelomonocytic leukemia, thrombocytopenia, history of falls, history of traumatic brain injury, and dependence on supplemental oxygen. Further review showed the client had problems of balance deficit, history of falls, and impaired swallowing. Review of the safety measures failed to show fall precautions, and blood and body fluid precautions. 8. Interview with the home health manager on 7/1/26 at 11 AM revealed the agency did not have a "Fall prevention strategy" policy to instruct or monitor patient / caregiver adherence. In addition, she confirmed there were no individualized fall safety care plans. Further, she revealed the agency did not have a policy for precautions on the plan of care.	G0574		

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30000	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 licensure survey was conducted by Healthcare Licensing and Surveys from 6/29/26 to 7/2/26.	S0000		
S1907	Organization and Administration CFR(s): Ch 9 Sec 5 (a)(viii) (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: (viii) Grievance Procedure. (A) The written grievance procedure shall establish a system of reviewing complaints and allegations of clients' rights violations to include, but not be limited to: (I) Client method to voice grievances; (II) Documentation of the home health agency's respond to verbal and written client grievances; (III) List of appropriate agencies, with addresses and telephone numbers for clients to contact if grievances are not addressed satisfactorily; and (IV) Written reports of all unresolved grievances shall be provided to the Licensing Division within ten (10) days after the grievance is filed with the home health agency. (If the ten (10) day requirement cannot be	S1907		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jennifer Brown	Manager	7/24/26

POC accepted. DOC 7/31/26. Janelle Cox MSG left for Jennifer Brown 7/31/26 3:10p.

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30000	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 licensure survey was conducted by Healthcare Licensing and Surveys from 6/29/26 to 7/2/26.	S0000	This has been corrected on 6/30/2026 by adding the LTC Ombudsmen information to the form "Home Care Bill of Rights" All old forms were disposed of on 6/30/2026 and all admission folders have been updated with the new forms this same day.	
S1907	Organization and Administration CFR(s): Ch 9 Sec 5 (a)(viii) (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: (viii) Grievance Procedure. (A) The written grievance procedure shall establish a system of reviewing complaints and allegations of clients' rights violations to include, but not be limited to: (I) Client method to voice grievances; (II) Documentation of the home health agency's respond to verbal and written client grievances; (III) List of appropriate agencies, with addresses and telephone numbers for clients to contact if grievances are not addressed satisfactorily; and (IV) Written reports of all unresolved grievances shall be provided to the Licensing Division within ten (10) days after the grievance is filed with the home health agency. (If the ten (10) day requirement cannot be	S1907	The policy titled Patients' BillofRights/ Responsibilities has been updated on 6/30/2026 to include the LTC Ombudsmen information including phone numbers, email and address.	7/2/26

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Manager	7/31/26