STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535017	A. Building B. Wing	08/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sublette County Health	333 N Bridger Ave Pinedale, WY 82941

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, medical record review, incident report review, and facility investigation review, the facility failed to ensure resident's were free from significant medication errors for 1 of 7 sampled residents (#1) reviewed. This failure resulted in harm to resident #1 who was hospitalized following an insulin overdose. The findings were: 1. Review of the admission Minimum Data Set assessment dated [DATE] showed resident #1 had a brief interview for mental status score of 3 out of 15, which indicated severe cognitive impairment, and had diagnoses which include heart failure, atrial fibrillation, renal insufficiency and diabetes mellitus. Further review showed the resident was insulin dependent for diabetes mellitus. The following concerns were identified: a. Review of the facility incident report dated 7/18/25 showed a potential medication error for resident #1 involving sliding scale insulin administration. b. Review of physician orders dated 7/10/2025 for sliding scale insulin showed the resident was to receive 8 units of insulin for blood sugars ranging from 351-400 mg/dl (milligrams per deciliter). c. Review of the resident's medication administration record dated 7/18/25 showed the residents blood sugar was 377 mg/dl prior to insulin administration.d. Review of the Mediation Error Report dated 7/18/25 showed registered nurse (RN) #1 administered 80 units of insulin instead of 8 units on 7/18/25. Further review showed the resident was transferred to an acute care hospital setting following the insulin administration utilizing the wrong type of syringe. e. Review of nursing report titled; Supplemental Statement of Events dated 7/19/25 showed RN #1 documented 8 units of insulin was administered to the resident at approximately 4:30 PM on 7/18/25. Further review showed the resident was not acting like him/herself and exhibited diaphoresis, cool skin, rapid breathing, and changes in level of consciousness. f. Review of the hospital physician note dated 7/19/25 showed the resident was admitted to the Intensive Care Unit for management for hypoglycemia and hypotension following accidental insulin overdose. g. Interview with RN #1 on 8/19/25 at 10:08 AM confirmed the resident was administered 80 units of insulin instead of 8 units on 7/18/25 at approximately 4:30 PM. She revealed during administration of the insulin, she utilized a tuberculin syringe instead of an insulin syringe because she couldn't find any insulin syringes.h. Interview with the director of nursing on 8/19/25 at 9 AM confirmed the wrong insulin dose was administered due to the nurse utilizing the wrong syringe for administration.

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 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