PRINTED: 02/09/2017
FORM APPROVED

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY0001	A. BUILDING: _____ B. WING _____	01/26/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMIE HOLT CARE CENTER	497 W LOTT BUFFALO, WY 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) COMPLETE DATE
S 000	OPENING COMMENTS Rules and Regulations utilized for this survey are: Rules and Regulations for Program Administration of Nursing Care Facilities, Chapter 11, effective 06/26/2000 Rules and Regulations for Licensure of Nursing Care Facilities, Chapter 19, effective 06/26/2000 A relicensure survey was conducted by Healthcare Licensing and Surveys on 1/23/17 through 1/26/17. The following common abbreviations are used throughout this document: ADLs: Activities of Daily Living CNA: Certified Nurse Aide DON: Director of Nursing MDS: Minimum Data Set RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	S 000		
S2978	Ch 11 Sec 9 (f)(i) Nursing Services The facility shall have sufficient nursing staff to meet the needs of the residents. (f) Administration of Drugs. Drugs shall be administered in compliance with federal and state laws, and in accordance with accepted professional principles. (i) Drugs shall be administered only by licensed nursing personnel in accordance with the Wyoming Nurse Practice Act.	S2978	The facility will ensure that medication is administered according to physician orders for residents receiving insulin by: A) Resident #40 insulin will be given according to the parameters ordered by his/her physician. B) All residents receiving insulin could be affected. The team leader for each floor will keep a daily written monitor of residents who receive insulin based on blood glucose levels. The team leader will record blood glucose values used to determine insulin usage and whether or not insulin was given or held appropriately	3/10/2017

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brenda Gorm, RN — TITLE: DON — (X6) DATE: 2.22.17

STATE FORM 6899 SAP211

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Plan of correction accepted on 2/22/17. I spoke with Brenda Gorm at 2:25pm. The DOC is 3/10/17

Jean Simi

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S2978	Continued From page 1 This State Rule and Regulation is not met as evidenced by: Based on observation, resident and staff interview,and medical record review, the facility failed to ensure medication was administered according to physician orders for 1 of 4 sample residents (#40) who received insulin. This failure resulted an incident of hypoglycemia requiring emergency treatment at the hospital for resident #40. The findings were: 1. Observation on 1/23/17 at 5:29 PM showed resident #40 was seated in the dining room with a plate of uneaten food in front of him/her. The resident was sweating, twitching, and combative. CNA #1 notified RN #1 of the situation. The RN asked for a glucometer and orange juice and then transferred the resident from the dining room chair into a wheelchair and removed the resident from the dining area. The resident's glucose level at that time was measured at 22 mg/dL (milligrams/deciliter). The resident was given a glucose gel orally and was taken to the emergency department (ER). 2. Review of the Emergency Room Note dated 1/23/17 showed the resident's blood glucose was measured at 23 mg/dL upon arrival at the hospital. 3. Review of a physician order dated 11/16/16 showed an order for 3 units of NovoLOG (short-acting insulin) 100 units/ml be injected SQ (subcutaneous) three times a day with meals. In addition the order stated "do not give if the BS (blood sugar) is less than 120." The following concerns were identified: a. Review of the medication record revealed the resident's blood sugar was	S2978	Continued From page 1 according to physicians orders. If insulin is not given or held appropriately, the team leader will intervene, notify the DON and initiate a medication error report. C) The DON will provide education to all nursing staff on each resident's insulin orders and the parameters established by the physicians. D) A tool will be implemented to ensure insulin is administered according to physician orders. This will be completed monthly and reported to quarterly to the PI committee. DON is responsible for compliance.	

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S2978	Continued From page 2 measured at 83 mg/dL on 1/23/17 at 4:40 PM, and 3 units of NovoLOG was administered to the resident at that time. b. Review of the medication record showed between 11/30/16 and 1/23/17 NovoLOG was administered 7 times when the resident's blood sugar measured between 100 mg/dL and 120 mg/dL. Further, NovoLOG was administered 5 times when the blood sugar was below 100 mg/dL. 4. Interview with the resident on 1/25/17 at 4:50 PM revealed that s/he had not been aware of the drop in his/her blood sugar on 1/23/17 when s/he had to go to the ER. In addition, s/he stated that s/he knew his/her blood sugar was too low (83 mg/dL) to receive the insulin and s/he knew it was too soon before dinner for the insulin to be administered, but "s/he figured the nurse knew what she was doing." 5. Interview with the DON on 1/25/17 at 11:25 AM revealed the nurse should not have administered the medication when the blood glucose was below 120 mg/dL. Further, each time the medication was administered outside the physician's parameters, a medication variance should have been completed and it was confirmed medication variances were not completed. 6. Interview with the DON and team leader #1 on 1/25/17 at 12:20 PM revealed the computer system did not provide a prompt or notification for the nurse not to administer the medication if the blood glucose was below the parameters for administration.	S2978		