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

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

(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
F0000	INITIAL COMMENTS A complaint survey was conducted by Healthcare Licensing and Surveys 8/18/25 through 8/19/25. The survey was prompted by complaint intakes WY2572095.	F0000		
F0760 SS = G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: 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 5/27/25 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.	F0760	The facility failed to ensure resident #1 was free from significant medication errors. To correct the deficient practice for resident #1, incorrect syringes were removed from the unit. Insulin syringes were labeled and placed in the medication cart with the vial of short acting insulin with resident name. To identify and correct potential deficient practice for other residents, all insulin was audited by the Director of Nursing for appropriate labels and storage. To prevent continued deficient practice, nurses were provided education on appropriate preparation and administration of insulin for both pens and vial on 08/19/2025. Further, insulin administration was placed on the required list of competency training for nurses. The Director of Nursing accepted responsibility for education and training on insulin administration. The Director of Nursing will continue to monitor and report as a function of regularly scheduled QAPI.	09/10/2025

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: 535017	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/19/2025

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F0760 SS = G	Continued from page 1 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.	F0760		