

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035092	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2026
NAME OF PROVIDER OR SUPPLIER Bella Vita Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5125 North 58th Avenue Glendale, AZ 85301	
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 - Minimal harm or potential for 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 clinical record reviews, staff and resident interviews, review of facility documentation, and policy and procedures, the facility failed to ensure one (#1) out of three sampled residents was free from a significant medication error. The deficient practice could result in resident discomfort or jeopardize the resident's health and safety. Findings Include: Resident #1 was initially admitted on [DATE], and re-admitted on [DATE], with a diagnosis that included anterior dislocation of left humerus, (primary) hypertension, cirrhosis of liver, chronic viral hepatitis C, iron deficiency anemia, schizophrenia, gastro-esophageal reflux disease, anxiety disorder, Waldenstrom macroglobulinemia, aphasia, hearing loss, and depression. An admission Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating Resident #1 was cognitively intact. Further review of the Section of Active Diagnosis revealed no evidence of active diagnosis for diabetes and no evidence of Resident #1 taking any insulin injections. A review of Resident #1's list of physicians' orders summary for June and July 2026 revealed no evidence of orders for insulin. Review of the care plan dated June 2026 through July 2026 for Resident #1 revealed no focused care area for Diabetes Mellitus. Vital signs record following blood sugar reading on July 1, 2026; at 5:45 PM: 96.0 milligrams per deciliter (mg/dL); at 6:00 PM: 51.0 mg/dL; at 6:20 PM: 79.0 mg/dL; at 6:40 PM: 97.0 mg/dL. A nursing progress note was entered into the clinical record for Resident #1 on July 1, 2026, at 7:19 PM, this revealed that at approximately 5:45 PM, the Registered Nurse (RN/Staff #3) inadvertently administered insulin to the wrong resident. The note identified that the error was immediately recognized, and the provider was notified without delay. The note further revealed that new orders were received by the doctor to monitor the resident's blood glucose every 15 minutes and once every hour and that Resident #1 was informed of the medication error and verbalized understanding. The note documented that the resident was placed on change of condition (COC) monitoring and that a call was placed to Resident #1's daughter to notify her of the incident; a voicemail message was left to return the call. Additionally the note documented that Resident #1 would be monitored closely for any signs or symptoms of hypoglycemia. All provider orders would be followed. Another nursing note dated July 1, 2026, at 7:24 PM revealed that Resident #1 was sent to the hospital per the provider's orders. Review of the RN (Staff #3) counseling and disciplinary action documentation revealed that a written warning was given to Staff #3 for administering insulin to the wrong resident on July 1, 2026, at 5:45 PM, which resulted in a medication error because she did not follow the rights of medication administration. Staff #3 received immediate one-on-one coaching with the Assisted Director of Nursing (ADON) regarding the medication error and the importance of adhering to the rights of medication administration using two resident identifiers, verification of the medication administration record (MAR), and following the medication administration process without deviation. Review of the facility internal medication error report completed on July 02, 2026, at 2:13 PM revealed that on July (continued on next page)		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 035092 If continuation sheet Page 1 of 3

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1, 2026, Staff #3 administered 18 units of insulin (Glargine) to the wrong resident, which was Resident #1. An interview was conducted on July 09, 2026, at 11:26 AM with Resident #1, who stated that on July 1, 2026, the nurse came to her with her medication with a large needle in her hand ; she stated to the nurse multiple times she was not diabetic and not to insert the needle in her and she stated the the nurse still gave her the injection. Resident #1 stated that after the nurse inserted the needle, she found out she was not diabetic; then the nurses rushed to her and did everything to bring back her blood sugar, but it was not going up. Resident #1 further stated that she was transferred to the hospital, and the doctor told her that she was in a danger zone. Resident #1 also stated that ever since then, she has been having headaches and has lost her appetite. An interview was conducted on July 9, 2026, at 1:39 p.m. with Staff #3, Registered Nurse (RN). Staff #3 stated that the five rights of medication administration are the correct resident, correct medication, correct dose, correct route, and correct time. Staff #3 stated that when administering medications, she first washes her hands, reviews the medication in the electronic medical record, applies the five rights of medication administration, verifies the medication three times, then proceeds to confirm the resident's identity using the room number and identification information before administering the medication. She stated that she identifies whether a resident is diabetic by reviewing the resident's medical record. She further stated that insulin should never be administered to a resident who is not diabetic because it places the resident at risk for hypoglycemia and constitutes a significant medication error. Staff #3 stated that on July 1, 2026, she was assigned to pass medications at the facility. She stated that she mistakenly administered 18 units of insulin intended for another resident to Resident #1. She stated that she does not recall the name or room number of the resident for whom the insulin was intended. Staff #3 explained that on July 1, 2026, a Certified Nursing Assistant (CNA) provided her with the blood glucose reading of 250 mg/dL for the resident who was prescribed the insulin. She went to that resident's room; however, the resident was not there. After waiting approximately 10 minutes, she began searching for the resident because the insulin administration was becoming overdue. She stated that she found another resident who resembled the profile photo of the intended resident. She approached Resident #1 and asked if the resident's name matched the name of the resident for whom the insulin was prescribed. Resident #1 responded, Yes, and Staff #3 administered the 18 units of insulin. Staff #3 stated that after the injection, Resident #1 repeatedly asked why insulin had been administered because she was not diabetic. Staff #3 stated that she immediately reviewed the medical record, recognized that she had administered the insulin to the wrong resident, and promptly notified the physician and the Assistant Director of Nursing (ADON). She stated that she followed the physician's orders, and Resident #1's blood glucose remained stable following the insulin administration. Staff #3 acknowledged that the incident constituted a significant medication error and stated that the potential risk to Resident #1 was hypoglycemia. An interview was conducted on July 10, 2026, at 10:03 AM with RN (Staff #4), who stated that the five rights of administering medication include the right resident, right medication, right route, right time, and right dose. She stated that she will administer medication to the resident by first reviewing the MAR to see what medication it is and if it is available, then pulling the medication, double-checking the dosage on the MAR, and checking the resident's wristband to ensure it is the right resident, introducing herself and telling the resident about the medication and get their consent if it is ok administer, double check the route, administer the medication, if the medication is to take orally and stand there until it is taken, then recheck the resident in 15 minutes if the resident is ok ensure there is no adverse side effects and recheck the resident 15-20 minutes. She stated that when administering insulin, she usually checks the MAR, checks if the medication is available match medication with the MAR, then enters the resident room, (continued on next page)		

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