STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366214	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canterbury Villa of Alliance	1785 Freshley Avenue Alliance, OH 44601

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** 28701 THIS IS AN EXAMPLE OF PAST NONCOMPLIANCE SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on medical record review, emergency room documentation review, review of the facility investigation, interview, review of the Lantus (glargine) Insulin prescribing information, review of www.insulins.lilly.com the facility failed to ensure medications were administered per physician orders resulting in a significant medication error. This affected one resident (Resident #73) of three residents reviewed for medications. Actual harm occurred on 03/14/25 at 10:30 P.M. when Resident #73, a diabetic resident who received insulin with meals and at bedtime, was administered the incorrect type of insulin (short acting instead of long-acting insulin) resulting in the resident having a headache, upset stomach and a blood sugar in low range. The physician was notified and ordered an emergency department transfer. Resident #73 was treated for hypoglycemia with intravenous fluids and concentrated intravenous dextrose before returning to the facility. Findings include: Review of Resident #73's medical record revealed an admitted [DATE] with diagnoses that included diabetes mellitus, urinary tract infection with sepsis and hypertension. Upon admission Resident #73 was ordered Humalog (rapid acting, mealtime insulin) six units subcutaneously (SQ) with meals and insulin glargine (long-acting insulin) 54 units SQ at bedtime. On 03/14/25 at 10:30 P.M. a progress note revealed Resident #73 was having a headache, upset stomach and blood sugar in low range. The physician was updated on patient status and ordered to end to the emergency department for evaluation. Resident #73 returned from the emergency department on 03/15/25 at 5:10 A.M. with no new orders. Review of the facility transfer out of facility form completed on 03/14/25 revealed the indication for transfer out was due to receiving the wrong medication. Review of the emergency department discharge summary dated 03/14/25 revealed Resident #73 was diagnosed with hypoglycemia (low blood sugar) due to insulin and administered intravenous (IV) dextrose 5% in water one liter and dextrose 25 grams per 50 milliliters by IV twice. (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

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F 0760 Level of Harm - Actual harm Residents Affected - Few	A physician's progress note dated 03/15/25 indicated Resident #73 had an emergency department evaluation after administered the incorrect dosage of Humalog. On 04/10/25 at 10:15 A.M. interview with the Director of Nursing confirmed Resident #73 was administered 54 units of Humalog instead of the ordered insulin glargine and was transferred to the emergency department for evaluation and treatment per the physician. Review of the facility investigation into the medication administration error revealed on 03/14/25 Resident #73 was administered 54 units of Humalog instead of insulin glargine as ordered by the physician by Licensed Practical Nurse (LPN) #91. A written statement by LPN #91 indicated that on 03/14/25 at 10:30 P. M. he administered the incorrect insulin to Resident #73. On 04/10/25 at 12:08 P.M. telephone interview with LPN #91 verified that he administered 54 units of Humalog insulin instead of the ordered insulin glargine to Resident #73 resulting in Resident #73 to be transferred to the emergency department for evaluation and treatment with IV dextrose for low blood sugar. During the interview the LPN stated the resident's blood sugar level was 75 (milliliters (ml) per deciliter (dL) of blood); however, the resident's blood sugar level was not documented in the medical record and there was limited information documented regarding the error. Review of the Lantus (glargine) prescribing information revised June 2023 revealed Lantus (glargine) is a long-acting insulin (works over an extended period of time). It is important to check insulin labels before administration. Review of the Humalog insulin patient information listed on www.insulins.lilly.com dated November 2023 revealed Humalog insulin is a rapid acting insulin that starts working faster and works for a shorter period of time than a regular (short acting) insulin. It is identified as a mealtime insulin taken within 15 minutes before or immediately after meals to help manage blood sugar levels after meals. Low blood sugar is a possible serious side effect of Humalog insulin, and it can cause dizziness, lightheadedness, headache, blurred vision, sweating, confusion, shakiness, fast heartbeat, anxiety, irritability, mood changes and hunger. Before injecting each insulin dose, check the insulin label to make sure that you are taking the correct insulin. Review of the facility policy Medication Administration dated 06/21/17 indicated that medication will be administered by legally authorized and trained persons in accordance with State, Local and Federal laws and consistent with accepted standards of practice. The deficiency was corrected on 03/24/25 after the facility implemented the following corrective actions: On 03/14/25 at 10:30 P.M. Resident #73 was assessed by Registered Nurse (RN) #95 for potential side effects. The resident's skin was warm and dry. The resident was alert and oriented to person, place and time. On 03/14/25 Resident #73's physician was notified of the medication administration error and ordered to send to the emergency department for evaluation and treatment. On 03/14/25 the Director of Nursing was notified of the medication administration error. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	On 03/14/25 Resident #73 was transferred to the emergency department for evaluation and treatment and returned on 03/15/25 with a diagnosis of hypoglycemia and treatment with IV dextrose. On 03/15/25, Resident #73 received his scheduled insulin without incident. On 03/19/25 LPN #91 completed online education for the following: Insulin Administration, Preventing Medication Errors, Medication Awareness and Safe Handling of Medicines and Preparing and Administering Insulin. By 03/24/25 all 25 nurses received Insulin Administration education provided by the Director of Nursing via handouts. On 03/24/25 an ad-hoc (not scheduled) Quality Assurance Performance Improvement (QAPI) meeting was held regarding the medication administration error. In-person attendees included the Administrator, DON, Assistant Director of Nursing (ADON), and Minimum Data Set (MDS). The medical director attended via phone. Audits of insulin and medication administration were completed by nursing administration staff on 03/19/25, 03/20/25, 03/25/25, 03/28/25 and 04/02/25 with no evidence of administration errors. LPN #91 was audited on 03/19/25 by Unit Manager #300. There were no additional identified medication administration errors as of 04/10/25. This deficiency represents non-compliance investigated under Master Complaint Number OH00164591 and Complaint Numbers OH00164431 and OH00164415.