

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366373	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Brookdale Westlake Village		STREET ADDRESS, CITY, STATE, ZIP CODE 28450 Westlake Village Drive Westlake, OH 44145	

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)
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43063</p> <p>Based on record review and interview, the facility failed to ensure medications to treat diabetes were administered as ordered by the physician. This affected one (#35) of one resident reviewed for medication errors. The facility census was 58.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #35 revealed an admitted [DATE] with diagnoses including diabetes mellitus.</p> <p>Review of the physician's orders for Resident #35 revealed she had an order for Novolog FlexPen 100 unit/milliliter, inject 10 units with meals for diabetes mellitus dated 09/05/24 and Insulin Detemir 100 units/milliliter, inject 55 units at bedtime for diabetes mellitus dated 09/06/24.</p> <p>Review of the nursing progress note dated 09/20/24 at 11:30 P.M. revealed Resident #35 was sent to the hospital. On 09/21/24 at 1:39 A.M. Resident #35 was administered her bedtime insulin and she had asked how many units of insulin she was being given. The nurse stated 55 units and administered the insulin. Resident #35 stated she gave her the wrong insulin after it had already been administered. The nurse checked the cart and realized she was out of her long-acting insulin (Insulin Detemir). Her blood sugar was obtained, and it was 125 (normal blood sugar range is 60-100). The physician was updated and completed a virtual visit with the resident who requested to be sent to the hospital for observation. On 09/21/24 at 6:00 A. M., Resident #35 returned to the facility with no new orders from the hospital.</p> <p>Review of the witness interview/statement form dated 09/21/24 revealed Licensed Practical Nurse (LPN) #397 went to administer Resident #35 her bedtime insulin at 9:20 P.M. Resident #35 asked her how many units of insulin she was being administered and LPN #397 stated it was 55 units, she administered the insulin and then the resident started screaming that she had given her too much insulin. LPN #397 stated she went to the cart and noticed the resident had been out of her nighttime insulin (Insulin Detemir). LPN #397 then took her blood sugar which was 125 and updated the physician. The statement said a virtual visit with the physician was held and the resident requested to be sent to the hospital.</p> <p>Interview on 09/30/24 at 3:47 P.M. with Resident #35 revealed LPN #397 had administered her the wrong insulin and dose on 09/20/24. She stated she went to the emergency room so that they could monitor her blood sugar.</p> <p>(continued on next page)</p>

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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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 10/02/24 at 10:39 A.M. with LPN #305 verified the medication error on 09/20/24 for Resident #35. She stated LPN #397 was an agency nurse who gave the wrong insulin to Resident #35. She stated she was supposed to get long-acting insulin (Detemir Insulin) and instead the nurse administered short-acting insulin (Novolog). LPN #305 stated the facility placed a do not return to the facility on agency nurse LPN #397. LPN #305 was unable to provide LPN #397's contact information.</p> <p>Review of the facility policy titled, General Dose Preparation and Medication Administration, dated 12/01/07, revealed staff should verify each time prior to a medication being administered that it was the correct medication and correct dose.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00157849.</p>		