STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435033	A. Building B. Wing	07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westhills Village Health Care Facility	255 Texas St Rapid City, SD 57701

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI) review, record review, interview, and policy review the provider failed to report to the SD DOH within the required time frame, for one of one sampled resident (1) who was sent to the emergency department, and hospitalized for observation and treatment after being administered the incorrect insulin by licensed practical nurse (LPN) D. Findings include: 1. Review of the provider's 5/4/25 SD DOH FRI regarding resident 1 revealed:*On 5/4/25 at 7:00 a.m. resident 1 was administered by injection 40 units of lispro (a fast-acting insulin) instead of the physician's ordered 40 units of glargine (a long-acting insulin) by LPN D.*At 7:04 a.m. physician G was notified of the medication error.-Resident 1 to receive an injection of glucagon (a medication used to increase the blood sugar in the body).-To continue encouraging resident 1 to eat and drink carbohydrates in an attempt to prevent resident 1's blood sugar from becoming too low.-To call the ambulance to have resident 1 transferred to the emergency department for further evaluation and treatment.*Resident 1 was admitted to the hospital overnight for observation of his blood sugars.*On 5/5/25 at 2:50 p.m. administrator A submitted the initial SD DOH FRI to report the medication error, which resulted in the resident's hospitalization for observation. 2. Review of resident 1's electronic medical record (EMR) revealed he:*Was admitted on [DATE].*Had a diagnosis of diabetes (a group of diseases that effect how the body uses sugar in the blood). *Had a 3/6/25 physician's order for Insulin glargine {U-100} 100 units/ml [units per milliliter] (3 ML) subcutaneous [under the skin] pen [generic] - 40 units Subcutaneous Every Day that was scheduled to be administered at 8:00 a.m.*Had previously been receiving lispro insulin, but that order was discontinued on 3/27/25 by physician G.*In April 2025 resident 1's blood sugars were measured four times daily.-The range of resident 1's blood sugars were 79-257.*Was transferred to the emergency room, after the medication error, on 5/4/25 at 7:27 a.m. and returned to the facility the morning of 5/5/25.*Was discharged from the facility on 6/17/25. 3. Review of resident 1's physician's progress notes from the resident's hospital stay above revealed:*He was evaluated in the emergency department after being administered 40 units of short-acting insulin instead of his prescribed 40 units of long-acting insulin.*Initially his blood sugars were maintained within a normal range by him eating but then dropped to 51 (a diabetic adult's blood sugar should be between 80-130) at around noon on 5/4/25.*An intravenous infusion of dextrose (sugar administered through the vein) was initiated when resident 1's blood sugar decreased to 51 and the intravenous dextrose infusion was maintained for a few hours to increase resident 1's blood sugar to a safe range.*He was admitted to the hospital for observation of his blood sugars and administration of the intravenous dextrose infusion.*Resident 1 was discharged in the morning on 5/5/25 with no changes in his medication orders. 4. Interview on 7/8/25 at 2:08 p.m. with physician G revealed:*He was the facility's medical director and resident 1's primary physician.*He was the on-call physician on 5/4/25 and received the phone call from the provider informing him of the medication error.*He stated, if the nurse had not reported her medication error immediately, the result of that medication error could have been critical.*He verified the administration of 40 units of lispro insulin instead of 40 units of glargine insulin was a significant medication error. 5. Interview on 7/8/25 at 3:20 p.m. with administrator A and director of nursing (DON) B revealed:*It was the provider's process that only the DON or administrator was able to submit a SD DOH FRI.*The administrator submitted the SD DOH FRI on 5/5/24 at 2:50 p.m., after she was notified of the medication error that resulted in resident 1's hospitalization.*The on-call nurse was notified of the incident shortly after the medication error had happened and assisted the staff with the processes of notifications to the physician and family, as well as resident 1's transfer to the emergency department.*Administrator A nor DON B expected the on-call nurse to have notified one of them of resident 1's medication error or his transfer to the emergency department. *They agreed that the transfer to the hospital needed to be reported to the SD DOH and administrator A stated she submitted the report as soon as she was made aware of the incident.*She verified she had not submitted the report to the SD DOH within 24 hours after the medication error, which resulted in resident 1 being transferred to the emergency department and admitted to the hospital. Review of the provider's 6/9/22 Abuse policy revealed:* Reporting / Response-Definitions:--Immediate: Means as soon as possible, the absence of a shorter State time frame requirement, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or serious bodily injury, or no later than 24 hours if the events that cause allegation do not involve abuse and do not result in serious bodily injury.* All alleged

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(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. (continued on next page)

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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI) review, record review, observation, interview, and policy review the provider failed to ensure one of one sampled resident (1) was free from a significant medication error when administered the wrong insulin by licensed practical nurse (LPN) D that resulted in the resident's transfer to the emergency room (ER) evaluation and treatment of low blood sugar levels, and a subsequent overnight hospitalization for observation.Findings include: 1. Review of the provider's 5/4/25 SD DOH FRI regarding resident 1 revealed:*On 5/4/25 at 7:00 a.m. resident 1 was administered by injection 40 units of lispro (a fast-acting insulin) instead of the physician's ordered 40 units of glargine (a long-acting insulin) by LPN D.*At 7:04 a.m. physician G was notified of the medication error. -Resident 1 to receive an injection of glucagon (a medication used to increase the blood sugar in the body). -To continue encouraging resident 1 to eat and drink carbohydrates in an attempt to prevent resident 1's blood sugar from becoming too low.-To call the ambulance to have resident 1 transferred to the emergency department for further evaluation and treatment.*Resident 1 was admitted to the hospital overnight for observation of his blood sugars.*On 5/5/25 at 2:50 p.m. administrator A submitted the initial SD DOH FRI to report the medication error, which resulted in the resident's hospitalization for observation. 2. Review of resident 1's electronic medical record (EMR) revealed he:*Was admitted on [DATE].*Had a diagnosis of diabetes (a group of diseases that effect how the body uses sugar in the blood).*Had a 3/6/25 physician's order for Insulin glargine {U-100} 100 units/ml [units per milliliter] (3 ML) subcutaneous [under the skin] pen [generic] - 40 units Subcutaneous Every Day that was scheduled to be administered at 8:00 a.m.*Had previously been receiving lispro insulin, but that order was discontinued on 3/27/25 by physician G.*In April 2025 resident 1's blood sugars were measured four times daily.-The range of resident 1's blood sugars were 79-257.*Was transferred to the emergency room, after the medication error, on 5/4/25 at 7:27 a.m. and returned to the facility the morning of 5/5/25.*Was discharged from the facility on 6/17/25. 3. Review of resident 1's physician's progress notes from the resident's hospital stay above revealed:*He was evaluated in the emergency department after being administered 40 units of short-acting insulin instead of his prescribed 40 units of long-acting insulin.*Initially his blood sugars were maintained within a normal range by him eating but then dropped to 51 (a diabetic adult's blood sugar should be between 80-130) at around noon on 5/4/25. *An intravenous infusion of dextrose (sugar administered through the vein) was initiated when resident 1's blood sugar decreased to 51 and the intravenous dextrose infusion was maintained for a few hours to increase resident 1's blood sugar to a safe range.*He was admitted to the hospital for observation of his blood sugars and administration of the intravenous dextrose infusion.*Resident 1 was discharged in the morning on 5/5/25 with no changes in his medication orders. 4. Observation and Interview on 7/8/25 at 12:05 p.m. with LPN F at the medication cart revealed:*The residents' insulins were stored in the top drawer of the medication cart once they were removed from the refrigerator for use.*LPN F was working on 5/4/25 at the time resident 1 received the wrong type of insulin.*She stated LPN D had administered 40 units of lispro insulin to resident 1 instead of his physician ordered 40 units of glargine insulin.*LPN F stated that resident 1 had physician ordered lispro insulin but that had been discontinued weeks prior.*The lispro insulin was not removed from the medication cart when it was discontinued but it should have been.*LPN D immediately recognized she had administered resident 1 the wrong insulin and reported the medication error to the on-call physician.*Resident 1's family and physician G were notified of the medication administration error, and resident 1 was transferred to the ER as ordered by physician G. 5. Interview on 7/8/25 at 1:45 p.m. with registered nurse (RN) E revealed: *All residents who had a physician's order for insulin were to have scheduled audits of the insulin on the resident's MAR.*The audits were to be completed and documented weekly by the nursing staff after they had checked all of the insulins in the medication carts. 6. Interview on 7/8/25 at 2:08 p.m. with physician G revealed:*He was the facility's medical director and resident 1's primary physician.*He had been the on-call physician on 5/4/25 and received the phone call from the provider informing him of the medication error.*Due to resident 1 having received 40 units of lispro insulin instead of his prescribed 40 units of glargine insulin, physician G ordered resident 1 to be transferred to the ER by ambulance for evaluation and treatment because he felt resident 1's condition was going to get worse before he returned to his baseline.*While in the emergency department resident 1's blood sugar decreased to 51 and required an intravenous infusion of dextrose to maintain his blood sugar in a safe range.*He stated, if the