STATEMENT OF DEFICIENCIES

(X1) PROVIDER/SUPPLIER/CLIA

IDENTIFICATION NUMBER:

(X3) DATE SURVEY COMPLETED

AND PLAN OF CORRECTIONS A. BUILDING 07/08/2025 435033 B. WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE Westhills Village Health Care Facility 255 TEXAS ST , RAPID CITY, South Dakota, 57701 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLÉTION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE DATE APPROPRIATE DEFICIENCY) F0000 **INITIAL COMMENTS** F0000 A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted on 7/8/25. Areas surveyed included possible facility acquired pressure ulcers, and the administration of an incorrect medication to a resident which resulted in a hospitalization. Westhills Village Health Care Facility was found not in compliance with the following requirements: F609 and F760. F0609 Reporting of Alleged Violations F0609 SS = D Westhills Village Health Care operates in compliance 08/06/2025 CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) with all relevant regulations and professional standards in a manner that ensures safe and §483.12(c) In response to allegations of abuse, appropriate care with an emphasis on residents' rights neglect, exploitation, or mistreatment, the facility for all residents we serve. must: In reference to F609, all staff will be educated on circumstances that require reporting including §483.12(c)(1) Ensure that all alleged violations appropriate timeframes on or before August 6, 2025. involving abuse, neglect, exploitation or mistreatment, The Director of Nursing, or designee, will conduct a random audit of three residents weekly for one month including injuries of unknown source and and then monthly for two months. Residents will be misappropriation of resident property, are reported assessed and interviewed to ensure that any events immediately, but not later than 2 hours after the are identified, properly investigated, and reported to allegation is made, if the events that cause the the appropriate people. Results will be reviewed by allegation involve abuse or result in serious bodily the QAPI committee for recommendations. injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: 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

FORM CMS-2567 (02/99) Previous Versions Obsolete

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Kelsey Bertsch

participation.

Event ID: ZVAQ11

ollowing the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program

Facility ID: 0003

Executive Director

TITLE

(X2) MULTIPLE CONSTRUCTION

08/01/2025 If continuation sheet Page 1 of 11

(X6) DATE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435033 NAME OF PROVIDER OR SUPPLIER		Sı	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING TREET ADDRESS, CITY, STATE, ZIP COD		EY COMPLETED	
vvestnii	lis Village Health Care Facility		25	5 TEXAS ST , RAPID CITY, South Dakota	ı, 57701	
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO APPROPRIATE DEFICIE	SHOULD BE TO THE	(X5) COMPLETION DATE
F0609 SS = D	Continued from page 1 Based on South Dakota Departacility reported incident (FRI) interview, and policy review the report to the SD DOH within the for one of one sampled reside emergency department, and heard treatment after being adminsulin by licensed practical numbers of the provider's 5/4 resident 1 revealed: 1. Review of the provider's 5/4 resident 1 revealed: *On 5/4/25 at 7:00 a.m. reside injection 40 units of lispro (a fainstead of the physician's order (a long-acting insulin) by LPN *At 7:04 a.m. physician G was medication error. -Resident 1 to receive an inject medication used to increase the body). -To continue encouraging reside carbohydrates in an attempt to blood sugar from becoming tood the emergency department of the treatment. *Resident 1 was admitted to the observation of his blood sugars. *On 5/5/25 at 2:50 p.m. administinitial SD DOH FRI to report the which resulted in the resident's observation. 2. Review of resident 1's electron (EMR) revealed he: *Was admitted on 1/3/25. *Had a diagnosis of diabetes (a effect how the body uses sugar. *Had a 3/6/25 physician's order.	artment of Health (SD DOH) I review, record review, the provider failed to the required time frame, tent (1) who was sent to the thospitalized for observation thinistered the incorrect turse (LPN) D. I/25 SD DOH FRI regarding Int 1 was administered by test-acting insulin) I red 40 units of glargine ID. Inotified of the Ition of glucagon (a the blood sugar in the Ident 1 to eat and drink I prevent resident 1's I low. I resident 1 transferred I for further evaluation and The hospital overnight for Sector A submitted the Ten medication error, Thospitalization for I group of diseases that I in the blood).	F0609			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435033 NAME OF PROVIDER OR SUPPLIER Westhills Village Health Care Facility		ST	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 07/08/2025 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 255 TEXAS ST , RAPID CITY, South Dakota, 57701				
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TAG	REGULATORY OR LSC IDE	ENTIFYING INFORMATION)	TAG	CROSS-REFERENCED APPROPRIATE DEFICIE	TO THE	COMPLETION DATE	
F0609 SS = D	Continued from page 2 {U-100} 100 units/ml [units persubcutaneous [under the skin Subcutaneous Every Day" the administered at 8:00 a.m. *Had previously been receiving order was discontinued on 3/2 *In April 2025 resident 1's block four times daily. -The range of resident 1's block four times daily. -The range of resident 1's block was transferred to the emerge medication error, on 5/4/25 at to the facility the morning of 5/2 *Was discharged from the facility was discharged from the facility the resident 1's physical from the resident's hospital state was evaluated in the emerge administered 40 units of instead of his prescribed	ar milliliter] (3 ML)] pen [generic] – 40 units at was scheduled to be Ig lispro insulin, but that 17/25 by physician G. Id sugars were measured Id sugars were 79-257. Id sugars were 79-257. Id sugars were 79-257. It yon 6/17/25. It yon 6/17/25. It yon 6/17/25. It you be a sugar suga	F0609	APPROPRIATE DEFICIT	ENCY)		
	blood sugars and administration dextrose infusion. *Resident 1 was discharged in with no changes in his medicati	the morning on 5/5/25					
	4. Interview on 7/8/25 at 2:08 p. revealed:	m. with physician G					
	*He was the facility's medical di 1's primary physician.	rector and resident					

STATI	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER: 435033		LIA		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURV 07/08/2025	EY COMPLETED
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PO609 SS = D	Continued from page 3 *He was the on-call physician the phone call from the provide medication error. *He stated, if the nurse had medication error could have be the verified the administration insulin instead of 40 units of gingificant medication error. 5. Interview on 7/8/25 at 3:20 A and director of nursing (DOI and director of nursing (DOI are administrator was able to subsect the staff with the processes administrator was able to subsect the medication error had the staff with the processes of physician and family, as well as to the emergency department. *Administrator A nor DON B exist to the emergency department. *Administrator A nor DON B exist to the emergency department. *Administrator A nor DON B exist to the emergency department. *Administrator A nor DON B exist to the emergency department. *Administrator A nor DON B exist to the emergency department and administrator to the sported to the SD DOH as the submitted the report as soof the incident. *She verified she had not subministration submitted the report as soof the incident. *She verified she had not subministrator and administrator an	der informing him of the obt reported her the result of that een critical. In of 40 units of lispro largine insulin was a special power of the powe	F06	009			

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	EMENT OF DEFICIENCIES PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLI IDENTIFICATION NUMBE 435033	ER/CLIA ER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURV 07/08/2025	EY COMPLETED
	NAME OF PROVIDER OR SUPPLIER Westhills Village Health Care Facility		1	TREET ADDRESS, CITY, STATE, ZIP COD		
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F0609 SS = D	Continued from page 4 serious bodily injury, or no late events that cause allegation of do not result in serious bodily *"All alleged violations-Immed -1) 2 hours- if the alleged violatesults in serious bodily injury: *"Serious bodily injury: Injury i physical pain; involving substate involving protracted loss or immof a bodily member, organ, or medical intervention such as a sor physical rehabilitation; or ar criminal sexual abuse". Residents are Free of Significate CFR(s): 483.45(f)(2) The facility must ensure that its §483.45(f)(2) Residents are free medication errors. This REQUIREMENT is NOT for the second protection interview, and polificate to ensure one of one sand free from a significant medication administered the wrong insulin nurse (LPN) D that resulted in the tothe emergency room (ER) events in the second protection. Findings include: 1. Review of the provider's 5/4/2 resident 1 revealed: *On 5/4/25 at 7:00 a.m. resident injection 40 units of lispro (a fast instead of the physician's order (a long-acting insulin) by LPN Desident insulin) by LPN Designer.	to not involve abuse and injury." liately but no later than ation involves abuse or ". Involving extreme antial risk of death; pairment of the function mental faculty; requiring surgery, hospitalization, injury resulting from ant Med Errors Serve of any significant MET as evidenced by: Itment of Health (SD DOH) review, record review, icy review the provider inpled resident (1) was on error when by licensed practical the resident's transfer valuation and treatment of ubsequent overnight 25 SD DOH FRI regarding It 1 was administered by st-acting insulin) ed 40 units of glargine in the resident of glargine in the part of the part	F0609	In reference to F760, Nurses and medic be re-educated on preventing medication through review of medication policies the Medication Passing Procedure discussion medication administration and include exproducts in use are appropriately stored including opened date, use by date, and appropriate per manufacturer's guidance will be completed on or before August 6 audits will be conducted by the Director designee two-three times weekly included medication administration including insurand administration will be audited, week month, then monthly for two months. Rereviewed by the QAPI committee for fur recommendations.	cation aides will on errors nat include ng the rights of ensuring that I and labeled, I discard as e. Education i, 2025. The of Nursing, or ing all shifts, ilin preparation ity for one esults will be	08/06/2025
	*At 7:04 a.m. physician G was r medication error.					
FORM CMS	-Resident 1 to receive an injecti -2567 (02/99) Previous Versions (Europe = 1			
OTAN ONS	-2001 (UZI99) PTEVIOUS VERSIONS (JDSOIETE	Event ID: ZVA	Q11 Facility ID: 0003	If continuation she	eet Page 5 of 11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS (X1) PROVIDER/SUPPLIDENTIFICATION NUMBER 435033		(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER: 435033	IA		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURV 07/08/2025	EY COMPLETED
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F0760 \$S = G	Continued from page 5 medication used to increase to body). -To continue encouraging resist carbohydrates in an attempt to blood sugar from becoming to to the emergency department treatment. *Resident 1 was admitted to the observation of his blood sugar *On 5/5/25 at 2:50 p.m. admininitial SD DOH FRI to report the which resulted in the resident's observation. 2. Review of resident 1's electre (EMR) revealed he: *Was admitted on 1/3/25. *Had a diagnosis of diabetes (a effect how the body uses sugar *Had a 3/6/25 physician's order {U-100} 100 units/ml [units per subcutaneous [under the skin] Subcutaneous Every Day" that administered at 8:00 a.m. *Had previously been receiving order was discontinued on 3/27 *In April 2025 resident 1's blood four times daily. -The range of resident 1's blood four times daily.	dent 1 to eat and drink o prevent resident 1's o low. e resident 1 transferred for further evaluation and he hospital overnight for s. istrator A submitted the he medication error, hospitalization for onic medical record a group of diseases that r in the blood). r for "Insulin glargine milliliter] (3 ML) pen [generic] – 40 units was scheduled to be lispro insulin, but that 1/25 by physician G. d sugars were measured l sugars were 79-257. hcy room, after the 1:27 a.m. and returned	F076	60	APPROPRIATE DEFICII	ENCY)	DATE
	*Was discharged from the facilit 3. Review of resident 1's physici from the resident's hospital stay	an's progress notes					
	*He was evaluated in the emerg being administered 40 units of s 2567 (02/99) Previous Versions C	ency department after hort-acting insulin					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435033 NAME OF PROVIDER OR SUPPLIER Westhills Village Health Care Facility		ST	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING TREET ADDRESS, CITY, STATE, ZIP CODEST TEXAS ST, RAPID CITY, South Dakota	07/08/2025 E	EY COMPLETED	
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F0760 SS = G	Continued from page 6 instead of his prescribed 40 unisulin. *Initially his blood sugars were normal range by him eating be diabetic adult's blood sugar shat "around noon" on 5/4/25. *An intravenous infusion of de administered through the vein resident 1's blood sugar decreintravenous dextrose infusion hours" to increase resident 1's range. *He was admitted to the hospi blood sugars and administration dextrose infusion. *Resident 1 was discharged in with no changes in his medical with no changes in his medical. 4. Observation and Interview of with LPN F at the medication of the medication cart once the refrigerator for use. *LPN F was working on 5/4/25 received the wrong type of insulin sulin to resident 1 instead of 40 units of glargine insulin. *LPN F stated that resident 1 hispro insulin but that had been prior. *The lispro insulin was not remicant when it was discontinued by the medication error to the on-call procession of the medication administration etransferred to the ER as ordered.	e maintained within a ut then dropped to 51 (a nould be between 80-130) extrose (sugar) was initiated when eased to 51 and the was maintained for a "few ablood sugar to a safe tal for observation of his on of the intravenous at the morning on 5/5/25 tion orders. an 7/8/25 at 12:05 p.m. eart revealed: tored in the top drawer bey were removed from the at the time resident 1 ulin. stered 40 units of lisprohis physician ordered discontinued weeks and physician ordered discontinued weeks	F0760	APPROPRIATE DEFICII	ENCY)	

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Westhills Village Health Care Facility 255 TEXAS ST , RAPID CITY, South Dakota, 57701 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETED IN COMPLETED	AND	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435033 NAME OF PROVIDER OR SUPPLIER		_	A. BUILDING 07/08/2025 B. WING			EY COMPLETED
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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 EN by ambulance for evaluation and treatment because he left resident 1's condition was going to get worse before he refurned to his baseline. "While in the emergency department resident 1's blood sugar decreased to 51 and required an intravenous infusion of dextose to maintain his blood sugar in a safe range. "He stated, if the nurse had not reported her medication error immediately, the result of that medication error or immediately, the result of that medication error. 7. Interview on 7/8/25 at 2:20 p.m. with LPN D revealed: "She was the nurse who mistakenelly admi	PREFIX	(EACH DEFICIENCY MUST	F BE PRECEDED BY FULL	PRE	FIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED	SHOULD BE TO THE	(X5) COMPLETION DATE
*There was an insulin pen for both the lispro and glargine insulins in the medication cart at the time of the medication error.		*All residents who had a physwere to have scheduled "audiresident's MAR. *The audits were to be completed by the nursing staff after they insulins in the medication cart. 6. Interview on 7/8/25 at 2:08 revealed: *He was the facility's medical 1's primary physician. *He had been the on-call physreceived the phone call from to of the medication error. *Due to resident 1 having receinsulin instead of his prescribe insulin, physician G ordered retransferred to the ER by ambute treatment because he felt resigning to get worse before he resident of the medication error immediately, medication error immediately, medication error could have be a the verified the administration insulin instead of 40 units of glisgnificant medication error. 7. Interview on 7/8/25 at 2:20 prevealed: *She was the nurse who mistated of lispro insulin to resident 1 insuling physician prescribed 40 units of the	eted and documented weekly had checked all of the is. p.m. with physician G director and resident sician on 5/4/25 and he provider informing him eived 40 units of lispro and 40 units of glargine esident 1 to be lance for evaluation and dent 1's condition was eturned to his baseline. rtment resident 1's blood quired an intravenous in his blood sugar in a streported her the result of that een critical. of 40 units of lispro argine insulin was a streported to the figlargine insulin.	F076	;O			

Westhills Village Health Care Facility STREET ADDRESS, CITY, STATE, ZIP CODE 255 TEXAS ST , RAPID CITY, South Dakota, 57701 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) FOR Continued from page 8 resident 1's MAR and identified there was no active physician's order for lispro insulin had been discontinued. *She knew resident 1 had previously had a physician's order for lispro insulin, but she was not sure when the order had been discontinued. *She thought the medication error could have been avoided if the lispro insulin had been removed from the cart and destroyed, and she would have completed the rights of medication administration prior to the administration of the insulin. *After the medication error she removed the lispro insulin from the medication cart and destroyed it. 8. Review of the July 2023 manufacturer's instructions for lispro insulin pens revealed: *"In-use Pen	COMPLETE
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) FOR COntinued from page 8 resident 1's MAR and identified there was no active physician's order for lispro insulin, but she was not sure when the order had been discontinued. *She knew resident 1 had previously had a physician's order for the lispro insulin, but she was not sure when the order had been discontinued. *She thought the medication error could have been avoided if the lispro insulin had been removed from the cart and destroyed, and she would have completed the rights of medication administration prior to the administration of the insulin. *After the medication error she removed the lispro insulin from the medication cart and destroyed it. 8. Review of the July 2023 manufacturer's instructions for lispro insulin pens revealed:	
resident 1's MAR and identified there was no active physician's order for lispro insulin in May 2025. *She knew resident 1 had previously had a physician's order for the lispro insulin, but she was not sure when the order had been discontinued. *She thought the medication error could have been avoided if the lispro insulin had been removed from the cart and destroyed, and she would have completed the rights of medication administration prior to the administration of the insulin. *After the medication error she removed the lispro insulin from the medication cart and destroyed it. 8. Review of the July 2023 manufacturer's instructions for lispro insulin pens revealed:	(X5) COMPLETION DATE
-Store the Pen you are currently using at room temperature [up to 86 degrees F [Fahrenheit] (30 degrees C [Celsius]). Keep away from heat and light. -Throw away the Insulin Lispro Pen you are using after 28 days, even if it still has insulin left in it." 9. Interview on 7/8/25 at 3:20 p.m. with administrator A and director of nursing (DON) B revealed: *The facility did not have medication that were identified as high-risk medications. *DON B stated she called the facilities pharmacy, and they indicated all medications are high-risk medications. *Administrator A and DON B stated the administration of 40 units of lispro insulin without a physician's order could have resulted in serious adverse effects, including death. *DON B verified resident 1's physician's order for lispro insulin had been discontinued on 3/27/25. *She expected that the nurse who received the order to discontinue the lispro insulin to have removed it from the medication cart and destroyed it at that time.	

TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Continued from page 9 discontinued from page 9 discontinued did not follow the provider's Medication Disposition policy. DON B and administrator A agreed that a discontinued insulin would be an insulin that should have been identified, removed, and destroyed during the weekly insulin audits according to, Discarding	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435033		IA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU A. BUILDING 07/08/2025 B. WING			RVEY COMPLETED	
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) FOR Continued from page 9 discontinued din tof follow the provider's Medication Disposition policy. **DON B and administrator A agreed that a discontinued insulin would be an insulin that should have been identified, removed, and destroyed during the weekly insulin audits according to, 'Discard' any products that are outdated or otherwise not indicated for use.' **DON B also verified the lispro insulin would have been taken out of the refrigerator at the latest date of 3/27/25, when the physician's order was received for discontinuation, and in accordance with the manufacturer's instructions it should have been destroyed 28 days after it had been opened, which meant the lispro insulin pen should have been destroyed 38 days after the lapse insulin audit was completed. That was four days after the lapse insulin should have been removed from the medication cart and destroyed 28 days after the lapse insulin should have been removed from the medication cart and destroyed 28 days after the lapse insulin should have been removed from the medication cart and destroyed 28 days after the lapse insulin should have been removed from the medication cart and destroyed 28 days after the lapse insulin should have been removed from the medication was a significant medication error. Pond B and administrator A agreed the administration of 40 units of lispro insulin instead of the physician's ordered 40 units of glargine insulin was a significant medication error. Review of the provider's 11/11/15 Medication Passing Procedure revealed: "Each individual medication must be checked with [the] MAR for:				- 1				
discontinued did not follow the provider's Medication Disposition policy. "DON B and administrator A agreed that a discontinued insulin would be an insulin that should have been identified, removed, and destroyed during the weekly insulin audits according to, Toiseadr any products that are outdated or otherwise not indicated for use; "DON B also verified the lispro insulin would have been taken out of the refrigerator at the latest date of 3/27/25, when the physician's order was received for discontinuation, and in accordance with the manufacturer's instructions it should have been destroyed 28 days after it had been opened, which meant the lispro insulin pen should have been destroyed 28 days after it had been opened, which meant the lispro insulin pen should have been destroyed 28 days after the lispro insulin should have been removed from the medication cart and destroyed 28 days after it had been opened, per the manufacturer's instructions. DON B and administrator A agreed the administration of 40 units of lispro insulin instead of the physician's ordered 40 units of glargine insulin was a significant medication error. Review of the provider's 11/11/15 Medication Passing Procedure revealed: "Each individual medication must be checked with (the) MAR for: a. Right medication c. Right medication c. Right medication	PREFIX	(EACH DEFICIENCY MUST	F BE PRECEDED BY FULL	PRE	FIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED	SHOULD BE FO THE	(X5) COMPLETION DATE
-d. Right time -e. Right route -f. Right effect -g. Right form -h. Right documentation".		discontinued did not follow the Disposition policy. *DON B and administrator A a insulin would be an insulin that identified, removed, and destrinsulin audits according to, "D are outdated or otherwise not *DON B also verified the lisprotaken out of the refrigerator at 3/27/25, when the physician's discontinuation, and in accord manufacturer's instructions it is destroyed 28 days after it had the lispro insulin pen should helater than 4/24/25. *DON B verified there was down MAR on 4/28/25 that the insuling that was four days after the listen removed from the medic days after it had been opened, instructions. DON B and administrator A ag 40 units of lispro insulin instea ordered 40 units of glargine instructions. DON B and administrator A ag 40 units of lispro insulin instea ordered 40 units of glargine instructions. Review of the provider's 11/11/Procedure revealed: *"Each individual medication medication error. Review of the provider's 11/11/Procedure revealed:	agreed that a discontinued at should have been royed during the weekly iscard any products that indicated for use." o insulin would have been at the latest date of order was received for lance with the should have been been opened, which meant ave been destroyed no cumentation in resident 1's in audit was completed. Spro insulin should have attion cart and destroyed 28 to per the manufacturer's greed the administration of d of the physician's sulin was a significant	F076	60			

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'	Nesthills	s Village Health Care Facility			255	TEXAS ST , RAPID CITY, South Dakota	, 57701	
PR	4) ID EFIX TAG	SUMMARY STATEMEN (EACH DEFICIENCY MUST REGULATORY OR LSC IDE	BE PRECEDED BY FULL	PR	ID EFIX AG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED T APPROPRIATE DEFICIE	SHOULD BE O THE	(X5) COMPLETION DATE
F07 SS	760 = G	Continued from page 10 Review of the provider's 3/6/1 policy revealed "Insulin pens a when opened and discarded p Review of the provider's Dece Disposition policy revealed: *"Medications that will not be a resident to whom they were di that are discontinued, outdate resident, will be disposed of pr will not be 'held for disposal' be dispositioned at the time that the service pending availability of a "Review for appropriate indicate medications, such as discontine order, etc."	9 Medication Insulin and vials will be dated per the pharmacy guidelines." Imber 2018 Medication Individual service of the spensed, such as those does not a such as those does not a such as those does not will be they were taken out of appropriate staff."	F07	760			