STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(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, South Dakota, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS 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.	F0000		
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily 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:	F0609	Westhills Village Health Care operates in compliance with all relevant regulations and professional standards in a manner that ensures safe and appropriate care with an emphasis on residents' rights for all residents we serve. In reference to F609, all staff will be educated on circumstances that require reporting including appropriate timeframes on or before August 6, 2025. The Director of Nursing, or designee, will conduct a random audit of three residents weekly for one month and then monthly for two months. Residents will be assessed and interviewed to ensure that any events are identified, properly investigated, and reported to the appropriate people. Results will be reviewed by the QAPI committee for recommendations.	08/06/2025

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F0609 SS = D	Continued from page 1 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 1/3/25. *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	F0609		

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F0609 SS = D	Continued from page 2 {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.	F0609		

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F0609 SS = D	Continued from page 3 *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	F0609		

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F0609 SS = D	Continued from page 4 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 violations-Immediately but no later than -1) 2 hours- if the alleged violation involves abuse or results in serious bodily injury". *"Serious bodily injury: Injury involving extreme physical pain; involving substantial risk of death; involving protracted loss or impairment of the function of a bodily member, organ, or mental faculty; requiring medical intervention such as surgery, hospitalization, or physical rehabilitation; or an injury resulting from criminal sexual abuse".	F0609		
F0760 SS = G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: 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	F0760	In reference to F760, Nurses and medication aides will be re-educated on preventing medication errors through review of medication policies that include Medication Passing Procedure discussing the rights of medication administration and include ensuring that products in use are appropriately stored and labeled, including opened date, use by date, and discard as appropriate per manufacturer's guidance. Education will be completed on or before August 6, 2025. The audits will be conducted by the Director of Nursing, or designee two-three times weekly including all shifts, medication administration including insulin preparation and administration will be audited, weekly for one month, then monthly for two months. Results will be reviewed by the QAPI committee for further recommendations.	08/06/2025

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F0760 SS = G	Continued from page 5 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 1/3/25. *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	F0760		

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F0760 SS = G	Continued from page 6 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	F0760		

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F0760 SS = G	Continued from page 7 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 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. 7. Interview on 7/8/25 at 2:20 p.m. with LPN D revealed: *She was the nurse who mistakenly administered 40 units of lispro insulin to resident 1 instead of the physician prescribed 40 units of glargine insulin. *There was an insulin pen for both the lispro and glargine insulins in the medication cart at the time of the medication error. *After she made the medication error, she reviewed	F0760		

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F0760 SS = G	Continued from page 8 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: *"In-use Pen -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. *DON B and administrator A verified the insulin having remained in the medication cart after it was	F0760		

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F0760 SS = G	Continued 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, "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 no later than 4/24/25. *DON B verified there was documentation in resident 1's MAR on 4/28/25 that the insulin audit was completed. That was four 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 Resident name -b. Right medication c. Right dose -d. Right time -e. Right route -f. Right effect -g. Right form -h. Right documentation".	F0760		

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F0760 SS = G	Continued from page 10 Review of the provider's 3/6/19 Medication Insulin policy revealed "Insulin pens and vials will be dated when opened and discarded per the pharmacy guidelines." Review of the provider's December 2018 Medication Disposition policy revealed: **"Medications that will not be administered to the resident to whom they were dispensed, such as those that are discontinued, outdated, or are declined by the resident, will be disposed of properly. Medications will not be 'held for disposal' but will be dispositioned at the time that they were taken out of service pending availability of appropriate staff." **"Review for appropriate indication to destroy medications, such as discontinuation of the medication order, etc."	F0760		