STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525266	A. Building B. Wing	03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Park Nursing and Rehab Ctr	718 Jupiter Drive Madison, WI 53718

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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30992 Based on interview and record review, the facility did not ensure residents are free of significant medication errors for 1 of 1 resident's reviewed for significant medication errors (R1). On 3/4/24, the facility received orders for R1 to receive Humalog sliding scale insulin. This order did not specify the frequency of administration. Two Registered Nurses (RN's) signed off on the order, but did not clarify how frequently the insulin was to be administered. Facility staff entered to administer the Humalog four times daily on R1's Medication Administration Record (MAR) without a clarification order from R1's physician. Additionally, R1 did not receive the Humalog insulin as ordered on 3/4/24, 3/5/24, 3/6/24, and 3/7/24. This is evidenced by: R1 was admitted on [DATE] with diagnoses including, but not limited to: diabetes mellitus type 2, morbid obesity, polymyalgia rheumatica (inflammatory disorder that primarily affects the shoulders and hips), major depressive disorder, anxiety, and asthma. R1's February physician orders, indicate the following order: Insulin Aspart Injection Solution 100 units/ml (milliliters) (Insulin Aspart) Inject as per sliding scale: If 141-180=3 units, 181-220=6 units, 221-260=9 units, 261-300=12 units, 301-350=15 units, 351+=18 units Call MD (Medical Doctor) if over 400, subcutaneously with meals for diabetes. (Order start date 12/6/23.) R1's Physician Orders, signed 2/29/24, and faxed to the facility on [DATE] indicates R1 is to receive the following medication: Insulin Lispro (Humalog Kwik pen) 100 unit/ML (milliliters) High Dose: Correction Insulin Bedside glucose should be done within 30-60 minutes of correction insulin administration. BG (Blood Glucose) Corrective Action Less than 70 follow Hypoglycemia guidelines 70-180 - No corrective insulin 181-220 Give 1 unit of insulin. 221-260 Give 3 units of insulin. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	261-300 Give 4 units of insulin. 301-350 Give 6 units of insulin. Greater than 350 Give 7 units of insulin and notify physician. If patient is eating meals and has orders for mealtime insulin combine and give at the same time. Note, the order is incomplete, as it does not specify the frequency of administration. Although this order was written on 2/29/24 it was not faxed to the facility until 3/4/24 at 5:08 PM. The order does not state to discontinue current sliding scale Aspart, or how to administer Humalog if resident is not receiving insulin with meals. On 3/6/24 the facility entered the following: Order Date: 3/6/24 5:08 PM Description: Please call Physician C's office to ask them to fax us orders for resident to be on insulin Lispro instead of Insulin Aspart - see Progress Note 3/6/24. One time only for follow up until 3/8/24. R1's Progress Note dated 3/6/24 at 6:11 PM indicates the following: Needing clarification for orders for resident to d/c (discontinue) insulin Aspart and instead start taking insulin Lispro. They (clinic) faxed incomplete orders for resident to be on Insulin Lispro - there were no details on when it should be scheduled or if it only is to be given with meals or if there is a different scale for bedtime? - also they did not fax order to d/c Insulin Aspart . R1's March 2024, MAR indicates R1 received Aspart sliding scale insulin instead of Humalog insulin on: 3/4 at 8:00 PM, 3/5 at 8:00 AM, 12:30 PM, 6:00 PM and 8:00 PM 3/6 at 8:00 AM, 12:30 PM, 6:00 PM and 8:00 PM and 3/7 at 8:00 AM and 12:30 PM. On 3/7/24 R1's MAR indicates the following: Humalog Kwik Pen Subcutaneous Solution Pen-Injector 100 unit/ml (Insulin Lispro) Inject as per sliding scale: If 70-180=No correction insulin 181-220= 1 unit 221-260= 3 units 261-300= 4 units (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	301-350= 6 units 351 or higher =7 units Greater than 350, give 7 units and notify physician. Subcutaneously four time a day for DM (Diabetes Mellitus) Start Date: 3/7/24 D/C (Discontinue Date): 3/22/24. Of note there is no order from the physician stating to give Humalog four times per day. The facility entered the frequency of four times daily 7:00 AM, Noon, 4:00 PM and 7:00 PM into R1's MAR without an order for frequency of administrating the insulin. On 3/27/24 at 2:45 PM, Surveyor asked DON B (Director of Nursing) regarding medication error report for R1. DON B stated there were no medication errors for R1. It is important to note, the facility did not identify nor investigate the significant medication errors. On 3/27/24 at 3:35 PM, Surveyor spoke with DON B. DON B and Surveyor reviewed R1's orders together. Surveyor asked DON B, should this order have been clarified to confirm frequency of administering the Humalog insulin. DON B stated, yes. Surveyor asked DON B, this order was faxed to the facility on [DATE], how soon should staff have called the Physician to clarify the order. DON B stated, the facility should not have waited 2-3 days to clarify the orders. DON B indicated staff should have followed up with the Physician immediately to clarify the insulin order frequency. DON B stated, he will be following up with Physician C and the facility's Medical Director today to ensure clarified orders are in place.