STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335358	A. Building B. Wing	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bronx Park Rehabilitation & Nursing Center	3845 Carpenter Ave Bronx, NY 10467

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. (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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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews during the Abbreviated Survey (2624284), the facility failed to ensure that residents are free of significant medication error. This was evident for 1 (Resident #1) of 3 residents reviewed for medication administration. Specifically, Resident #1 was administered sixty (60) units of insulin when six (6) units was the physician ordered dose.The findings are:A Facility Reported Incident and Investigation dated 09/25/2025, documented that on 09/21/2025 at 7:14AM, Resident #1 was administered 60 units of insulin instead of 6 units of insulin. Licensed Practical Nurse #1 reported the medication error to Registered Nurse #1, the supervisor. Resident #1 was transferred to the hospital for observation.Resident #1was admitted to the facility with active diagnoses that included Non-Alzheimer's Dementia and Diabetes Mellitus with unspecified complications. The Minimum Data Set quarterly assessment dated [DATE], identified the resident's cognitive status as severely impaired. A Physician's Order dated 09/21/2025, documented Humulin Neutral Protamine [NAME] (NPH) Insulin subcutaneous suspension 100 Unit/Milliliter four (4) units to be administered subcutaneously every eight (8) hours.A Nursing Progress Note dated 09/21/2025, documented that during medication pass, Licensed Practical #1 realized that more insulin coverage was mistakenly administered to Resident #1. Blood glucose reading 189mg/dl.A Nursing Progress Note dated 09/21/2025, documented that Licensed Practical Nurse #1 reported to Registered Nurse #1, the nursing supervisor, that at approximately 7:14 AM a medication error had occurred. Resident #1 had a standing order for Humulin Neutral Protamine [NAME] (NPH) Insulin six (6) units to be administered every eight (8) hours. Licensed Practical Nurse #1 administered a higher dose of sixty (60) units of Humulin Neutral Protamine [NAME] (NPH) Insulin. Resident #1 was transferred to the hospital at 8:45 AM due to risk for hypoglycemia.A Glucose Monitoring Log dated 09/21/2025, documented Resident #1 had a blood glucose reading of 163mg/dl. Licensed practical Nurse #1 administered an insulin dose of sixty (60) units. Noted as a medication error. A Physician Progress Note dated 09/21/2025, documented Resident #1 was transferred to the hospital emergency room for observation after a Humulin Neutral Protamine [NAME] (NPH) Insulin medication error.A Transfer Form dated 09/21/2025, documented Resident #1 was transferred to the hospital for observation and increased risk of hypoglycemia. Resident #1 was accidently given high dose of insulin, sixty (60) units of Humulin Neutral Protamine [NAME] (NPH) Insulin.A Nursing Medication Incident and Accident Report dated 09/21/2025 7:14 AM, documented a physician's order for Humulin Neutral Protamine [NAME] (NPH) Insulin six (6) units to be administered to Resident #1, Licensed Practical Nurse #1 administered sixty (60) units of Humulin Neutral Protamine [NAME] (NPH) Insulin. Resident #1 was transferred to the hospital at 8:45 AM due to risk for hypoglycemia. Nurses were In-serviced on medication pass and insulin administration.On 10/29/2025 at 10:17 AM, Licensed Practical Nurse #1 was interviewed and stated that they were employed by the facility through a nursing agency. Licensed Practical Nurse #1 stated that on 09/21/2025 they checked the physician orders for Resident #1, and the resident was scheduled to receive six (6) units of insulin Humalog Humulin Neutral Protamine [NAME] (NPH). The resident did not have an insulin pen, so the insulin had to be drawn from a vial. They thought they drew up six (6) units of insulin but when they went to enter the six (6) unit dosage in the medication administration record (MAR), they realized that they had administered sixty (60) units of insulin to Resident #1. Licensed Practical Nurse #1 also stated that they informed the nursing supervisor of the medication error immediately. The Resident was assessed to be alert with vital signs stable and a blood glucose reading of 189 milligrams/deciliter (mg/dl) and was transported to the hospital for observation. On 10/28/2025 at 11:51 AM, an interview was performed with Registered Nurse #1, the nursing supervisor, who stated that they were working the night shift as the nursing supervisor on the 12am-8am on 09/21/2025 when Licensed Practical Nurse #1 called. Upon arrival on Unit Six (6), Licensed Practical Nurse #1 stated that they administered the wrong dose of insulin to Resident #1, Humulin Neutral Protamine [NAME] (NPH) Insulin sixty (60) units instead of six (6) units. Licensed Practical Nurse #1 then demonstrated that they had drawn up sixty (60) units from the insulin vial with a U one hundred (U100) syringe. Registered Nurse #1 also stated that they had not performed any previous medication observations with Licensed Practical Nurse #1. Registered Nurse #1 further stated that an assessment on the resident was performed. The Resident was alert with a blood glucose reading of 180 milligrams/deciliter (mg/dl). and no signs or symptoms of hypoglycemia. The Physician Assistant, the Director of Nursing and the Resident's family were called, and