

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445286	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/01/2025
NAME OF PROVIDER OR SUPPLIER Fairpark Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 307 N Fifth St Box 5477 Maryville, TN 37801	

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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, and interviews, the facility failed to prevent a medication error for 1 resident (Resident #40) of 6 residents reviewed for medication administration.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, Medication Administration, revised 6/1/2025, revealed .Medications are administered .as ordered by the physician and in accordance with professional standards of practice .Identify resident by photo in the MAR [Medication Administration Record] .Review MAR to identify medications to be administered .verify resident name, medication name, form, dose, route, and time .</p> <p>Review of the medical record revealed Resident #40 was admitted to the facility on [DATE] with diagnoses including Cerebral Infarction, Morbid (Severe) Obesity, and Chronic Pain Syndrome.</p> <p>Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #40 scored a 15 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact.</p> <p>Review of a Nursing Progress Note for Resident #40 dated 9/27/2024, revealed .resident [Resident #40] . was given [Resident #40's room-mate] meds [medications] instead of her [Resident #40's] .LPN [Licensed Practical Nurse] .called on call [Nurse Practitioner] [NP] at 2000 [8:00 PM] .On call stated recheck VS [vital signs] in 2 hrs [hours], do not give Lyrica [medication used to treat nerve pain] .due to getting a Gabapentin [medication used to treat nerve pain], resident could experience drowsiness .ED [Executive Director] and DON [Director of Nursing] were notified .will continue to monitor .</p> <p>Review of a facility document titled, Investigation Significant Medication Error, for Resident #40 dated 9/27/2024, revealed .Date error began 9/27/2024 .Date error found 9/27/2024 .Incorrect Medication .Doxepin [medication used to treat depression] 10mg [milligrams], Tylenol [medication used to treat pain or fever] 500mg, Famotidine [acid reducer] 20mg, Gabapentin 100mg, Senna [medication used to treat constipation] 8.6mg/50mg .No adverse reactions .Nurse .Re-educated on the 6 rights of med admin [administration] .</p> <p>(continued on next page)</p>

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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/29/2025 at 11:38 AM, Resident #40 stated several months ago (unable to recall the exact date) she was administered her room-mates medications (unable to recall what medications were administered). Resident #40 stated she was awakened by a nurse (unable to recall the nurses name) and handed a medication cup which contained 5 pills and the resident typically took two pills. Resident #40 questioned the nurse about the number of pills but took the medication the nurse had prepared. Resident #40 stated the nurse returned to the room after she had questioned the number of pills and informed the resident she had been given the room-mate's medications. Resident #40 further stated the nursing staff checked on her frequently throughout the night and she did not experience any adverse reactions after she received the wrong medications.</p> <p>During a telephone interview on 6/30/2025 at 4:47 PM, Resident #40's responsible party stated in September 2024 (unsure of the exact date) a nurse (unable to recall the nurse's name) at the facility administered Resident #40 the wrong medications. The responsible party stated the staff at the facility called her every hour to give an update on Resident #40's status and the resident had no reaction after she received the wrong medications.</p> <p>During a telephone interview on 6/30/2025 at 5:04 PM, LPN C stated she vaguely remembered the medication error which involved Resident #40. LPN C stated she prepared Resident #40's room-mate's medications. The LPN went into Resident #40's room, verbalized Resident 40's room-mate's name and Resident #40 stated .hey . LPN C stated she administered the cup of medications (unable to recall what medications) to Resident #40 after the resident stated hey. LPN C stated Resident #40 had asked what the medications were, the LPN went to verify the medications, and identified she had administered the wrong medications to Resident #40. LPN C stated Resident #40, the Nurse Practitioner (NP), the resident's responsible party, the Administrator, and the DON were made aware of the medication error immediately. LPN C stated the staff monitored Resident #40 and her vital signs frequently throughout the night and the resident had no adverse reactions after she received the wrong medications.</p> <p>During an interview on 7/1/2025 at 12:28 PM, the Administrator confirmed LPN C administered Resident #40 the wrong medication on 9/27/2024.</p> <p>During an interview on 7/1/2025 at 1:46 PM, the NP stated she was familiar with Resident #40 and the medication error which occurred on 9/27/2024. The NP stated she was notified immediately after the medication error occurred and the resident had no adverse outcomes from the medication error.</p>		