STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445415	A. Building B. Wing	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nhc Healthcare, Farragut	120 Cavett Hill Lane Knoxville, TN 37922

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, and interview, the facility failed to assess and obtain a physician's order for medication self-administration for 1 resident (Resident #128) of 1 resident reviewed for self-administration of medication. The findings include:Review of the facility's policy titled, Self-Administration of Medications, dated 2/2025, revealed, a physician order should be obtained then an assessment is conducted by a member of the interdisciplinary team of the resident's cognitive .physical, and visual ability to carry out this responsibility .a member of the interdisciplinary team verifies the resident's ability to self-administer medications by means of a skill assessment conducted on a quarterly basis .the results of the interdisciplinary team member's assessment of resident skills .are recorded in the resident's medical record .Review of the medical record revealed Resident #128 was admitted to the facility on [DATE] with diagnoses including Diabetes, Heart Failure, and Lung Disease. Review of a Social Services Progress Note dated 2/3/2026, revealed Resident #128 scored a 15 on the Brief Interview for Mental Status (BIMS) assessment, which indicated the resident was cognitively intact. Review of the Physician Order Report dated 2/2/2026-2/11/2026, revealed Resident #128 had an order .insulin aspart [fast-acting insulin to regulate elevated blood sugar levels] .for use of insulin pump, and uses 1 vial every 2 days .please send . and an order, .May use Dexcom [type of insulin pump] . There was no Physician's Order for Resident #128 to self-administer the insulin by refilling the insulin pump with the insulin from a vial sent by the pharmacy. Review of the medical record revealed Resident #128 did not have documentation an assessment had been completed for the resident's ability to self-administer medication.During an interview on 2/11/2026 at 9:15 AM, Resident #128 stated he cared for and refilled his insulin pump himself, using insulin the facility pharmacy provided. Resident #128 was knowledgeable on the process of refilling the insulin pump in a safe and appropriate manner. During an interview on 2/11/2025 at 9:55 AM, the Director of Nursing (DON) confirmed an assessment on the ability to self-administer medication and a Physician's Order to self-administer medication had not been obtained by the facility.

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)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the facility policy review, Lippincott Nursing Center website review, medical record review, and interviews, the facility failed to ensure basic nursing standards for the rights of medication administration were followed for 1 resident (Resident #12) of 7 residents reviewed for insulin administration.The findings include:Review of the facility's policy titled, Specific Medication Administration Procedures, dated 2/25/2025, revealed .Review medications for accuracy .Check MAR/TAR [Medication Administration Record/ Treatment Administration Record] for order .Prior to administering medication .check the label [medication label] against the order [Physician's order] on the MAR .Review of the Lippincott Nursing Center Website resource of the Nursing Drug Handbook dated 2025- 2026, revealed .Medication Errors in Nursing .As a final step in the administration process .and the .defense against medication errors .nurses must follow the rights of medication administration .Right Patient .Right medication .Right dose .Right route .Right time .Right Documentation .Right reason .Right response .Review of the medical record revealed Resident #12 was admitted to the facility on [DATE] with diagnoses including Chronic Kidney Disease, Diabetes, and Diabetic Neuropathy. Review of a comprehensive care plan for Resident #12 dated 8/18/2021, revealed .Diabetes- at risk for adverse effects .due to use of .insulin .Approach .Administer insulin as ordered .Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #12 scored a 13 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact. Further review revealed Resident #12 had an active diagnosis of Diabetes and received insulin injections. Review of a Physician's Order Report for Resident #12 dated 11/1/2025 -11/30/2025, revealed the resident was prescribed Humalog Kwikpen insulin (Lispro) (an injectable medication used to rapidly lower blood glucose levels) 200 unit/milliliter (u/ml), to give 3 units subcutaneously before meals (start date 6/19/2025) and Lantus Solostar (Glargine) (an injectable medication used to gradually lower blood glucose levels) 100 u/ml, give 32 units subcutaneously at bedtime (start date 7/17/2025). Review of a nursing progress note for Resident #12 dated 11/7/2025 at 10:50 PM, revealed .[Resident #12] Received Humalog 32 units [the Humalog order was for 3 units] instead of prescribed Lantus 32 units [received at approximately 10:30 PM] .MD [Medical Doctor] notified .Review of a Telehealth Consult visit (a virtual medical visit with a physician) for Resident #12 dated 11/7/2025 at 10:51 PM, revealed .insulin overdose .Received Humalog 32 units instead of prescribed Lantus 32 units approximately 20 minutes prior to encounter [Telehealth visit] .Glucose measured at 197 milligram/deciliter (mg/dl) [approximately 10:30PM], then dropped to 146 mg/dl [at approximately 10:50 PM] after insulin administration .No symptoms reported with current glucose levels .Accidental administration of rapid-acting insulin .in place of long acting insulin .Currently asymptomatic with stable vital signs and blood glucose levels within acceptable range.No immediate need for hospital transfer; will monitor closely in the facility for now .Continue close observation for any symptoms of hypoglycemia .including lightheadedness, dizziness, or altered mental status .Ensure blood glucose remains above 90 mg/dl; if glucose drops below this threshold despite interventions, consider transfer to the emergency department . (normal blood glucose ranges 70-100 mg/dl). Review of a nursing progress note for Resident #12 dated 11/7/2025 at 11:15 PM, revealed .Patient [Resident #12] sent to [Hospital] for evaluation and treatment .no signs of hypoglycemia, however BG [Blood Glucose] 116 [116 mg/dl] [approximately 25 minutes] after glucose gel X [times] 2 [2 doses] given .Patient eating peanut butter crackers and drinking sprite .Review of a comprehensive care plan for Resident #12 revised 11/7/2025, revealed .Diabetes- at risk for adverse effects .due to use of .insulin .Approach .Administer insulin as ordered .send to ER [Emergency Room] for eval [evaluation] of possible impending hypoglycemia .Review of an emergency room (ER) visit note for Resident #12 dated 11/7/2025, revealed .Adm [Admit] Date 11/7/2025 23:37 [11:37 PM] .comes to us [ER] after being given 32 units of Humalog versus Lantus (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.At this time glucose is 70 Will continue to monitor .he [Resident #12] is p.o. [by mouth] tolerant so he is eating and drinking at this time .he [Resident #12] is asymptomatic .Review of a nurse progress note for Resident #12 dated 11/8/2025 at 7:24 AM, revealed .Patient returned [to the facility] via stretcher/ EMS [Emergency Medical Services] .During an interview on 2/10/2026 at 1:48 PM, Resident #12 stated he had a diagnosis of Diabetes and was prescribed 3 units of fast acting insulin (Humalog/lispro) three times per day and 32 units of long-acting insulin (Lantus) one time per day at bedtime. Resident #12 stated in November 2025 (unable to recall the exact date) the night shift nurse (unable to recall the nurses name) accidentally administered 32 units of the fast-acting insulin instead of the long-acting insulin. Resident #12 stated he remained asymptomatic after the incident but agreed to go to the ER for an evaluation after he was requested to go by the nurse. During a telephone interview on 2/11/2026 at 2:17 PM, Licensed Practical Nurse (LPN) A stated she recalled the insulin medication error on 11/7/2025 which involved Resident #12. LPN A stated at approximately 9:30 PM-10:30 PM (unable to recall the exact time) she retrieved an Insulin pen, prescribed for Resident #12, from the medication cart and administered 32 units from the Humalog insulin pen (LPN A thought she had retrieved the Lantus insulin pen and retrieved the Humalog pen in error). LPN A stated when she returned to the medication cart, she immediately realized she had administered Humalog 32 units instead of the ordered dose of Lantus. LPN A stated Resident #12 remained asymptomatic and showed no signs of hypoglycemia after the incorrect dosage of insulin was administered or prior to being transported to the ER. LPN A further stated for precautionary measures she requested for Resident #12 to be transferred to the local ER for evaluation. LPN A confirmed she failed to follow the eight rights of medication administration and did not verify the medication label on the insulin pen matched the Physician's order for Resident #12, prior to administering the insulin. During an interview on 2/11/2026 at 2:23 PM, the Medical Director stated he was at the facility 4 days per week, was very familiar with Resident #12, and the insulin error on 11/7/2025. The Medical Director stated had he been the provider on call on 11/7/2025, he would have ordered the necessary treatment in house to treat any hypoglycemic episodes to prevent the ER visit. The Medical Director stated he agreed with the transfer of Resident #12 to the ER as recommended by the Telehealth Consult and LPN A, for precautionary measures. The Medical Director stated the LPN's prompt identification and quick response to the insulin administration error prevented any harm or adverse effects to Resident #12. During an interview on 2/11/2026 5:11 PM, The Director of Nursing (DON) stated she recalled the insulin medication error on 11/7/2025 with Resident #12. The DON confirmed LPN A failed to follow the eight rights of medication administration and did not verify the medication label on the insulin pen matched the Physician's order prior to administering the insulin to Resident #12 which resulted in the medication error.