STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445506	A. Building B. Wing	06/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Preserve at Fairfield Glade	100 Samaritan Way Crossville, TN 38558

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 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 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 and physician's orders were followed for 1 resident (Resident #26) of 7 residents reviewed for medication administration. The findings include: Review of the facility's policy titled, Medication Administration Policy and Procedures, dated 6/2025, revealed Nurses prepare and administer medications, only with orders from a licensed prescriber and follow the community policies and procedures .Nurses follow the seven rights of medication administration including: Right resident, Right medication, Right dose, Right route, Right time, Right recording, and Right reason .All medication labels should be checked three (3) times with the eMAR [Electronic Medication Administration Record] prior to administration .Vital signs and blood sugar monitoring is done prior to giving medications as indicated per order .Check the insulin label to make sure it is the right kind of insulin .Select the correct dose of insulin per order . 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 #26 was admitted to the facility on [DATE] with diagnoses including Paroxysmal Atrial Fibrillation (A-Fib), Hypertension, Diabetes Mellitus, and Adrenocortical Insufficiency (occurs when the adrenal glands do not produce enough hormones, particularly cortisol). Review of an admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #26 scored a 15 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact. Further review revealed the resident had an active diagnosis of Diabetes and Hypertension. Continued review revealed the resident received insulin injections.ˆ Review of a comprehensive care plan dated 5/11/2026 for Resident #26, revealed .I have hypertension .will remain free of complication related to hypertension .Diabetes Mellitus with risk for complications .I will remain free of complications related to diabetes . Review of a Physician's Order Report for Resident #26 revealed .Insulin Glargine [an injectable medication used to gradually lower blood glucose levels] .100 UNIT/ML [milliliter] .Inject 80 unit subcutaneously one time a day .Order Date 05/11/2026 .NovoLOG [an injectable medication used to rapidly lower blood glucose levels] .100 UNIT/ML .Inject 6 unit subcutaneously before meals .Order Date 05/15/2026 .Verapamil [medication used to treat hypertension] .Give 240 mg [milligram] by mouth one time a day .Hold if DBP [Diastolic Blood Pressure] < [less than] 55 .or HR [Heart Rate] <60 .Order Date 05/04/2026 . Review of the Nurse's Notes for Resident #26 revealed .5/25/2026 19:21 .[7:21 PM] .This RN [Registered Nurse] A went into elder's [Resident #26's] room with evening medications took her [Resident #26] blood sugar 372, and gave her [Resident #26] insulin, after I [RN A] returned to the medication cart realized I [RN A] have given Novolog [short acting insulin] instead of Glargine [long acting insulin], Immediately called the facility Medical Director [MD] and reported .error, gave elder [Resident #26] a peanut butter and jelly sandwich and will monitor her blood sugar every couple of hours all night long, call (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	placed to Director of Nursing [DON] . Review of a Skilled Nursing Note for Resident #26 revealed .05/26/2026 02:30 [2:30 AM], revealed .Medication error with short acting insulin this evening, however she [Resident #26] ate a peanut butter and jelly sandwich, and her [Resident #26] blood sugar has remained in the 300's all night long. Blood sugar every couple of hours to monitor throughout the night .Pt [Patient] [Resident #26] has experienced no signs .of hypoglycemia [low blood sugar] .Elder [Resident #26] has been alert and oriented and blood sugars have remained in the 300's range . Review of a Medication Administration Record (MAR) for Resident #26 dated 5/1/2026 - 5/31/2026, revealed .Verapamil .240 MG .Hold if DBP <55 or HR <60 . Further review revealed on 5/16/2026, Resident #26's DBP was 50, on 5/20/2026 the DBP was 51, and on 5/22/2026 the HR was 57. Continued review revealed the Verapamil was administered and not held per the physician's order. Review of a Weights and Vitals Summary Report for Resident #26 revealed on 5/16/2026 at 7:23 PM the resident's DBP was 72 (after Verapamil was administered) and on 5/20/2026 at 6:53 PM, the resident's DBP was 68 (after Verapamil was administered). Further review revealed on 5/22/2026 at 1:20 PM Resident #26's HR was 70 (after Verapamil was administered). Continued review revealed blood glucose levels were monitored every 2 hours starting on 5/25/2026 at 8:46 PM and the lowest blood glucose level reading was 274 which was obtained on 5/26/2026 at 7:29 AM (the morning after Resident #26 was administered the wrong insulin). During an interview on 6/3/2026 at 8:50 AM, Resident #26 stated she was administered the incorrect insulin on 5/25/2026. The resident also stated RN A informed her of the error and notified the Doctor immediately.she [RN A] gave me a peanut butter and jelly sandwich after she [RN A] talked to the Doctor .they [facility staff] kept me up all night checking me .she [RN A] knew what to do .it was no big deal .I have done the same thing at home before . Resident #26 also stated she had not had a hypoglycemic episode after the wrong dose of insulin had been administered, did not require hospitalization, and had no other ill effects. During an interview on 6/3/2026 at 9:13 AM, RN A stated she administered the wrong insulin to Resident #26 on 5/25/2026. The resident had a Physician's order to administer Insulin Glargine 80 units and RN A administered Novolog 80 units. RN A stated the resident had 3 insulin pens in the medication drawer .I picked up the wrong one [insulin pen] .as soon as I got back to the med [medication] cart I realized I had picked up the wrong pen . RN A immediately notified the MD and was given orders to check Resident #26's blood glucose levels every 2 hours throughout the night and give the resident a peanut butter and jelly sandwich. RN A worked night shift and monitored the glucose levels as ordered, the resident's blood glucose levels remained well above normal, the resident did not have any hypoglycemic episodes and did not require emergent treatment. RN A confirmed she administered the wrong medication to Resident #26 and failed to follow the rights for medication administration. During a telephone interview on 6/3/2026 at 2:15 PM, the MD stated he was notified immediately when Resident #26 was administered 80 units of a short acting insulin on 5/25/2026. The MD also stated he ordered the facility to obtain blood glucose levels every 2 hours throughout the night. Resident #26's blood glucose levels remained elevated, the resident did not have a hypoglycemic episode, and there was no ill effects or harm to the resident. During an interview on 6/3/2026 at 3:05 PM, the RN MDS Coordinator confirmed Resident #26 was administered Verapamil 240 MG on 5/16/2026, 5/20/2026, and 5/22/2026 and was not held per the physician's orders. During a telephone interview on 6/3/2026 at 3:15 PM, the MD stated he expected the facility to follow all his orders for Resident #26. During an interview on 6/3/2026 at 3:30 PM, the Administrator confirmed RN A failed to follow the 7 rights of medication administration for Resident #26.