### Summary Statement of Deficiencies

#### N 002

**1200-8-6 No Deficiencies**

During the Annual Licensure Survey, complaints TN-28405 and TN-28433 were investigated. No deficiencies were cited under State Licensure for the complaints.

#### N 733

**1200-8-6-06(6)(f) Basic Services**

1. **Pharmaceutical Services.**
   1. All oral orders shall be immediately recorded, designated as such and signed by the person receiving them and countersigned by the physician within ten (10) days.

   **This Rule is not met as evidenced by:**
   - Based on medical record review and interview, the Nurse Practitioner failed to timely sign and date a Physician’s Telephone Order, for one (#14) of thirty residents reviewed.

   **The findings included:**
   - Resident #14 was admitted to the facility on January 20, 2007 with diagnoses including Anoxic Brain Injury, Seizure Disorder, Psychosis, and Pulmonary Embolism.

   Medical record review of a Physician’s Order dated June 29, 2011, revealed an order to “discontinue Tramadol due to increased risk of seizure.”

   Medical record review of the Medication Administration Record revealed Tramadol had been administered to resident #14 on July 4, 2011, at 9:30 a.m., and on July 8, 2011 at 6:30 a.m.

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**HILLCREST HEALTHCARE-NORTH**

5321 BEVERLY PARK CIRCLE
KNOXVILLE, TN 37918

**ID TAG:**

- N 002
- N 733

**ID PREFIX:**

- N

**DATE:**

- 9-23-11
N 733 Continued From page 1

Review of the facility policy regarding Medication Orders and review, revealed
"... 2. A current list of orders must be maintained in the clinical record of each resident ...and ...
4. Physician orders/Progress Notes must be signed and dated ...

Interview with LPN #7, third floor Team Leader on September 7, 2011, at 8:05 a.m., in the third floor nurses station confirmed there was no physician's order to continue Tramadol in the medical record.

Interview with the Administrator and DON (Director of Nursing) on September 8, 2011, at 11:05 a.m., in the Administrator's office revealed, that after contacting the pharmacy, a telephone order by the Nurse Practitioner to continue Tramadol had been sent to the pharmacy on June 30, 2011. The telephone order was undated and unsigned by the Nurse Practitioner. The pharmacy faxed the telephone order to the facility on September 8, 2011, at 8:58 a.m. Continued interview confirmed the order was not signed and dated as required.

Assurance Performance Improvement Committee meeting consisting of Administrator, Director of Nursing, Medical Director, Therapy Manager, Activity Director, Dietary Manager, MDS Coordinator, Assistant Directors of Nursing, Team Leaders, Admissions Director, Social Services, Facilities Maintenance Director, Business Office Manager, Housekeeping Director and Laundry Director.