STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARILLON ASSISTED LIVING OF GARNER	200 MINGLEWOOD DRIVE GARNER, NC 27529

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an initial survey on 10/10/18 - 10/12/18.	D 000		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 3 of 4 residents sampled (#1, #2, #3) including errors with a blood pressure medication (#1); a patch for dementia (#2); an antihistamine for allergies and a multivitamin (#3). The findings are: 1. Review of Resident #2's current FL-2 dated 06/04/18 revealed diagnoses included dementia, fall, disease of thyroid gland, hypertension, and macular degeneration. Review of Resident #2's physician's order dated 09/28/18 revealed an order for Lidocaine Patch 5%, apply 1 patch to back in the morning and remove in the evening. (Lidocaine Patch is a topical anesthetic used to treat pain.)	D 358		

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Review of Resident #2's October 2018 medication administration record (MAR) revealed:
-There was an entry for Lidocaine Patch 5%, apply 1 patch topically to back once a day for 12 hours then remove (12 hours on / 12 hours off).
-The Lidocaine Patch was scheduled to be administered at 8:00am and removed at 8:00pm.
-The Lidocaine Patch was documented as administered and removed from 10/02/18 - 10/10/18.

Observation of the 8:00am medication pass on 10/11/18 revealed:
-At 8:18am, the medication aide (MA) / Garden Place Coordinator (GPC) removed a Lidocaine Patch 5% from Resident #2's lower right back.
-The MA/GPC then applied a new Lidocaine Patch 5% to Resident #2's lower left back at 8:19am.

Interview with the MA/GPC on 10/11/18 at 8:19am revealed:
-The old Lidocaine Patch 5% from the previous day should not have been left on the resident's back.
-It was supposed to be removed at 8:00pm on the previous day.
-There was not usually a patch left on the resident from the day before when she administered medications on first shift.
-She did not know why staff documented the patch was removed when it was not removed.

A second interview with the MA/GPC on 10/11/18 at 11:58am revealed:
-In the past, about two months ago, some MAs reported that staff had not removed the Lidocaine Patch as ordered.
-The MAs were reminded to the remove the patch

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D 358	Continued From page 2 and she was not aware of any problems again until today. Interview with the Regional Nurse on 10/11/18 at 12:37pm revealed: -The Lidocaine Patch should be removed at 8:00pm each day. -Resident #2's Lidocaine Patch should have been removed on 10/10/18 at 8:00pm. -The MAs had been trained to follow the orders on the MARs. Based on observations, interviews, and record reviews, it was determined that Resident #2 was not interviewable. 2. Review of Resident #3's current FL-2 dated 04/10/18 revealed diagnoses included essential hypertension, dyspnea on exertion, chronic kidney disease - stage IV, pressure ulcer - buttock, osteoarthritis, and pulmonary emboli. -There was an order for Multivitamin 1 tablet daily. (Multivitamin is a supplement.) -There was an order for Allegra 180mg daily. (Allegra is an antihistamine for allergies.) Review of Resident #3's August 2018 - October 2018 medication administration records (MARs) revealed: -There was an entry for Multivitamin take 1 tablet once daily and it was scheduled to be administered at 8:00am on each MAR. -Multivitamin was not documented as administered on 8 occasions including 08/25/18, 08/28/18 through 08/31/18, 09/01/18, 09/03/18, and 09/05/18 due to the medication being unavailable. -There was an entry for Allegra 180mg take 1 tablet once daily and it was scheduled to be administered at 8:00am on each MAR.	D 358		

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-Allegra was not documented as administered on 8 occasions including 08/27/18 through 09/03/18 due to the medication being unavailable.

Observation of Resident #3's medications on hand on 10/12/18 at 12:32pm revealed:
-There were 30 Allegra 180mg tablets dispensed on 10/01/18 and 23 remained.
-There were 30 Multivitamin tablets dispensed on 09/27/18 and 23 remained.

Interview with a medication aide (MA) on 10/12/18 at 12:42pm revealed:
-The MAs were responsible for ordering medications when they got to the blue strip on the bubble cards.
-The MAs were supposed to pull the stickers off the bubble cards and fax the order to the pharmacy or they could order on the electronic MAR system.
-She did not know why Resident #3's Multivitamin and Allegra were unavailable for 8 days each.

Telephone interview with primary pharmacy triage technician on 10/12/18 at 4:58pm revealed:
-A 30 day supply of Resident #3's Allegra was dispensed on 04/25/18, 05/20/18, 06/20/18, 07/20/18, 09/05/18, and 10/01/18.
-A 30 day supply of Resident #3's Multivitamin was dispensed on 04/25/18, 05/16/18, 06/20/18, 07/12/18, 09/05/18, and 09/27/18.
-The facility was not on a cycle fill so they had to order medications when needed.
-He did not know why there was a delay in the ordering of Resident #3's Allegra and Multivitamin.
-There appeared to be refills on both medications.

Interview with Resident #3 on 10/10/18 at

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D 358	Continued From page 4 10:16am revealed: -She took "a lot" of medications. -Some of her medications were for high blood pressure, high cholesterol and arthritis. -The medication aides (MAs) administered the medications to her. -She did not know if they had ever run out of her medication because she took so many pills. Interview with the Resident Care Coordinator (RCC) on 10/12/18 at 4:34pm revealed: -The MAs were supposed to order medications when there was a 7 day supply left. -She was not sure why Resident #3's Allegra and Multivitamin were unavailable in August and September 2018. 3. Review of Resident #1's current FL-2 dated 04/17/18 revealed: -Diagnoses included dementia, hypertension, macular degeneration, hyperlipidemia, atrial fibrillation, depression, osteoarthritis, premature separation of placenta afibrinogenemia. -There was an order for Diltiazem (used to treat high blood pressure and to control angina (chest pain)) 60mg, one capsule per oral twice a day. Review of Resident #1's medication administration record (MAR) for August 2018, September 2018 and October 2018 revealed: -There was an entry for Diltiazem 60mg, take one tablet by mouth twice daily at 8:00am and 8:00pm. -There was documentation that Resident #1 did not receive her 8:00pm dose of Diltiazem on 08/17/18 and 08/23/18. -There was documentation notes on the Medication Notes page of the August 2018 MAR that Resident #1 did not receive her 8:00pm dose of Diltiazem on 08/17/18 and 08/23/18 because	D 358		

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she refused.
-There was documentation that Resident #1 did not receive both her 8:00am and 8:00pm doses of Diltiazem on 10/06/18 thru 10/08/18.
-The documentation on the Medication Notes page of the October 2018 MAR noted that on 10/06/18 the staff person was unsure as to whether Resident #1's 8:00am dose of Diltiazem was given.
-The documentation on the Medication Notes page of the October 2018 MAR noted that on 10/06/18 the 8:00pm dose of Diltiazem was not in the medication cart.
-The documentation on the Medication Notes page of the October 2018 MAR noted that on 10/07/18 the 8:00am dose of Diltiazem was not in the medication cart.
-The documentation on the Medication Notes page of the October 2018 MAR noted that on 10/07/18 the 8:00m dose of Diltiazem was not in the medication cart.
-The documentation on the Medication Notes page of the October 2018 MAR noted that on 10/08/18 the 8:00am dose of Diltiazem was "not applicable (N/A)".
-The documentation on the Medication Notes page of the October 2018 MAR noted that on 10/08/18 the 8:00pm dose of Diltiazem was not in the facility.

Telephone interview with primary pharmacy triage technician on 10/12/18 at 4:58pm revealed:
-A 30 day supply of Resident #1's Diltaizem was dispensed on 04/26/18, 05/22/18, 07/02/18, 07/28/18, 08/30/18, and 10/07/18.
-The facility was not on a cycle fill so they had to order medications when needed.
-He did not know why there was a delay in the ordering of Resident #1's Diltiazem.
-There appeared to be refills on the medication.

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D 358	Continued From page 6 Interview with medication aide/supervisor (MA/S) on 10/12/18 at 5:15pm revealed: -She was off work on 10/06/18 thru 10/08/18 and did not know that Resident #1 had not received her Diltiazem on those days. -When she was on the medication cart, she ordered a refill of the medication when the count reached eight in the bubble package. -Whoever was on the medication cart is responsible for ordering a refill of the medication when they noticed that the medication count was low. -There was also a medication cart audit performed by the Resident Care Coordinator (RCC), the Administrator-in-Training (AIT) or the Regional Nurse and if there were any medications on the medication cart that were low in count that a refill had not been ordered, they ordered it at that time. Interview with the Regional Nurse on 10/12/18 at 5:10pm revealed: -Everyone that worked on the medication cart was responsible for ordering refills of medications. -If the medication was not on the medication cart when the dose was due, then the staff should notify the pharmacy. -Then, if the facility still had not received the medication from the pharmacy, the staff should call the physician. -Medication refills were ordered when there was a seven day supply or when the doses in the bubble package reached the blue area on the package, it is also an indicator that the medication refill needed to be ordered.	D 358		

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D 364	10A NCAC 13F .1004(g) Medication Administration	D 364		

10A NCAC 13F .1004(g) Medication Administration

10A NCAC 13F .1004 Medication Administration
(g) The facility shall ensure that medications are administered to residents within one hour before or one hour after the prescribed or scheduled time unless precluded by emergency situations.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to assure medications were administered within one hour before or after the prescribed or scheduled times for 1 of 4 residents sampled (#3) whose medications scheduled for 8:00am were administered over 3 hours late on 10/10/18, including 5 medications that were scheduled to be administered more than once a day.

The findings are:

Review of the facility's resident roster on 10/10/18 revealed there were 13 residents residing on the assisted living (AL) side of the facility.

Interview with the Administrator-in-Training (AIT) on 10/10/18 at 9:45am revealed:
-There were 13 residents on the AL side of the facility.
-One of the 13 residents was in the hospital and not in the facility that morning.

Review of Resident #3's current FL-2 dated 04/10/18 revealed:
-Diagnoses included essential hypertension, dyspnea on exertion, chronic kidney disease - stage IV, pressure ulcer - buttock, osteoarthritis, and pulmonary emboli.
-There was an order for Zinc 220mg once daily.

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(Zinc is a supplement.)
-There was an order for Metoprolol 25mg 2 tablets daily. (Metoprolol lowers blood pressure.)
-There was an order for Vitamin C 500mg daily. (Vitamin C is a supplement.)
-There was an order for Torsemide 10mg daily. (Torsemide is a diuretic.)
-There was an order for Prednisone 5mg daily. (Prednisone is a corticosteroid used to treat inflammation.)
-There was an order for Multivitamin 1 tablet daily. (Multivitamin is a supplement.)
-There was an order for Glucosamine 1,000mg twice daily. (Glucosamine is a supplement used to treat arthritis and joint pain.)
-There was an order for Gabapentin 100mg 2 capsules 3 times a day. (Gabapentin may be used to treat nerve pain or mood disorders.)
-There was an order for Allegra 180mg daily. (Allegra is an antihistamine for allergies.)
-There was an order for Febuxostat 40mg daily. (Febuxostat is used to treat gout.)
-There was an order for Vytorin 10/20mg daily. (Vytorin is used to treat high cholesterol.)
-There was an order for Diclofenac gel 1% apply 2 grams 4 times a day transdermally. (Diclofenac gel is used to treat arthritis.)
-There was an order for Calcium with Vitamin D 600/200 take 1 tablet daily. (Calcium with Vitamin D is a supplement.)

Review of Resident #3's physician's orders revealed:
-There was an order dated 04/26/18 to change to Metoprolol XL 50mg daily.
-There was an order dated 07/06/18 to change to Prednisone 1mg take 3 tablets daily.
-There was an order dated 04/26/18 to change to Diclofenac gel 1% apply 4 grams twice a day to knee, hip, and left lower back.

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-There was an order dated 09/26/18 for Nystatin powder, apply topically 4 times a day. (Nystatin is a topical antifungal powder.)

Interview with Resident #3 on 10/10/18 at 10:16am revealed:
-She took "a lot" of medications.
-Some of her medications were for high blood pressure, high cholesterol and arthritis.
-The medication aides (MAs) administered the medications to her.
-Sometimes she received her medications about 2 hours late in the morning and sometimes at night.
-She thought the facility may be short staffed which may have caused them to be late with her medications.

Interview with the MA on 10/10/18 at 10:38am revealed:
-She was working as the supervisor, MA, and assisting with personal care on the AL side of the facility for first shift today.
-She was the only MA administering medications for both halls with residents on the AL side.
-She was running late with the morning medications because she had also been helping residents get dressed.
-She ran late administering medications when she also helped with personal care.
-She would sometimes have to help with personal care 5 days a week.
-She usually started the medication pass in the AL at 7:00am and she usually finished the medication pass around 10:00am.
-She had not notified anyone that she was running late with the medication pass.
-Management knew she was administering medications and providing personal care to residents.

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-She had one resident left to administer 8:00am medications to that morning.

Observations of the MA on 10/10/18 revealed:
-At 10:56 am, the MA was at the medication cart in the hallway preparing medications to be administered.
-At 11:00am, the MA was in Resident #3's room administering medications.

Interview with the MA on 10/10/18 at 11:06am revealed:
-She just administered Resident #3's oral and topical medications that were scheduled for 8:00am.
-She had gotten behind with the medication pass that morning because she was assisting with personal care to residents in addition to administering medications.

Interview with Resident #3 on 10/10/18 at 11:19am revealed:
-She ate breakfast at 8:00am this morning.
-She had just received her morning medications from the MA.
-She sometimes received her morning medications late, around 10:00am.
-She did not usually receive her medications as late as she did today.

Review of Resident #3's October 2018 medication administration record (MAR) revealed:
-There were 14 medications scheduled for morning doses at 8:00am.
-Five of the 14 medications were scheduled to be administered more than once a day. (For medications with multiple administrations, consistent time intervals are necessary to prevent side effects and adverse reactions.)
-Multivitamin, Vytorin, Allegra, Metoprolol XL,

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Prednisone, Torsemide, Febuxostat, Vitamin C, and Zinc were all scheduled once daily at 8:00am.
-Calcium with Vitamin D, Diclofenac gel, and Glucosamine were all scheduled to be administered twice daily at 8:00am and 8:00pm.
-Gabapentin was scheduled to be administered 3 times daily at 8:00am, 2:00pm, and 8:00pm.
-Nystatin powder was scheduled to be administered 4 times daily at 8:00am, 12:00pm, 4:00pm, and 8:00pm.

Confidential interview with two residents revealed they sometimes got their medications late.

Interview with a second MA on 10/12/18 at 2:45pm revealed:
-If a MA had to administer medications and provide personal care on the AL side on first shift, the mediations could run late at times.
-The morning medication pass had run late "at times" when she was administering medications on the AL side.
-She did not know if management was aware the medication pass had run late at times.

Interview with the Regional Nurse on 10/10/18 at 4:23pm revealed:
-There was usually at least 1 MA working on each side of the facility, the AL and the SCU on first and second shifts.
-The MAs had been trained to administer medications within the one hour before and one hour after the scheduled time frame.
-No MAs had voiced any concerns to her about not having enough time to finish the medication passes in the required time frame.

Interview with the AIT on 10/10/18 at 4:35pm revealed:

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-There was usually 1 MA working on the AL side of the facility and 1 MA in the special care unit on first shift.
-She was not aware of any concerns with medications being administered late.
-If a MA was running late with the medication pass, the MA should notify the Resident Care Coordinator (RCC).

Interview with the RCC on 10/11/18 at 9:28am revealed:
-She sometimes administered medications in the facility to give the MAs a break.
-She was available in the facility to help administer medications.
-No MAs had reported to her that they were running late on administering medications.

D 392 | D 392

10A NCAC 13F .1008(a) Controlled Substances

10A NCAC 13F .1008 Controlled Substances
(a) An adult care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to assure readily retrievable records and failed to account for the use and administration of controlled substances for 2 of 4 residents sampled (#3, #5) including a resident receiving a medication for anxiety and agitation (#5) and a resident receiving a medication for moderate to severe pain.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARILLON ASSISTED LIVING OF GARNER	200 MINGLEWOOD DRIVE GARNER, NC 27529

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D 392	Continued From page 13 The findings are: 1. Review of Resident #5's current FL-2 dated 06/13/18 revealed: -Diagnoses included dementia, Parkinson's disease, congestive heart failure, hypertension, atrial fibrillation, and dysphagia. -There was an order for Lorazepam 1 to 2mg by mouth every 4 to 6 hours as needed for anxiety. (Lorazepam is a controlled substance used to treat anxiety and agitation.) Review of a subsequent physician's order dated 06/23/18 for Resident #5 revealed an order for Lorazepam 0.5mg every 6 hours as needed for anxiety/agitation. Review of Resident #5's Resident Register revealed the resident was admitted to the facility on 06/20/18. Confidential staff interview revealed: -Some medication aides (MAs) discovered during controlled substance shift counts a few days ago that Resident #5 had 3 missing pills. -Resident #5 lived in the special care unit. -Staff could not recall the name of the missing pills. Review of Resident #5's June 2018 - October 2018 medication administration records (MARs) revealed: -There was an entry on each MAR for Lorazepam 0.5mg 1 tablet every 6 hours as needed for anxiety/agitation. -Lorazepam was documented as administered 2 times from 06/01/18 - 10/12/18. -Lorazepam was documented as administered on 06/21/18 at 5:05pm and 06/22/18 4:59pm. -Only two doses of Lorazepam 0.5mg tablets	D 392		

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were documented as administered since the resident was admitted to the facility.

Review of Resident #5's controlled substance (CS) log for Lorazepam revealed:
-Resident #5's name and medication information was handwritten on the computer printed CS log.
-The medication was Lorazepam and 50 doses were received on 06/20/18.
-The tablets were documented as round, white and halved.
-The dose noted 0.5mg (or ½ tablet) every 6 hours as needed for agitation.
-The first documented dose administered was 06/21/18 at 5:05pm and a second dose on 06/22/18 at 4:56 (am or pm not specified).
-The third entry was dated 07/18/18 at 6:55am and the word "wasted" was documented with two staff signature/initials beside it.
-A fourth entry was dated 09/20/18 at 3:25 (am or pm not specified) and the word "wasted" was documented with two staff initials beside it.
-Doses #46, 45, and 44 were circled and marked through with no other documentation.
-No reasons were documented for the 3 doses marked through.
-Dose #43 was circled and the words "count verified" was documented with some staff signature/initials.
-No date was documented for the verified count of 43 tablets.

Observation of Resident #5's medications on 10/12/18 at 8:46am revealed:
-There was a prescription bottle with a faded label making it difficult to read the information printed on the label.
-Resident #5's name and "Lorazepam 1mg tablet" was printed on the label.
-The instructions were faded but appeared to

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read, take ½ tablet every 4 to 6 hours as needed for agitation.
-The date and quantity dispensed information on the label was faded and could not be read.
-There were 43 half tablets of Lorazepam 1mg.

Interview with a medication aide/supervisor (MA/S) on 10/12/18 at 8:46am revealed:
-The resident's family brought the Lorazepam when the resident moved into the facility.
-She used to be able to read the label but the label had faded and it was difficult to see the writing on the label now.

Interview with the Regional Nurse on 10/12/18 at 2:27pm revealed:
-They did not usually document medications brought in by family members.
-If it was a controlled substance, they would document the amount brought in as the starting count on the CS log.
-The starting amount documented on Resident #5's CS log for Lorazepam would be the amount brought in by the family when she was admitted to the facility.

Telephone interview with Resident #5's power of attorney (POA) on 10/12/18 at 3:12pm revealed:
-Resident #5 was admitted to the facility in June 2018.
-The family took some medications to the facility when the resident was admitted which "likely' included Lorazepam.
-She did not recall which pharmacy the medications came from because the resident lived with another family member prior to the facility.
-Some of the medications may have been dispensed by non-local pharmacies.
-She did not know how many Lorazepam tablets

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D 392	Continued From page 16 were taken to the facility. -She did not recall how the medication labels looked when they took them to the facility. -She had no concerns about Resident #5's medications. Interview with a MA on 10/12/18 at 12:45pm revealed: -The MAs always counted all of the controlled substances at shift change. -One of the doses documented as "wasted" on Resident #5's CS log occurred when they dropped a pill on the floor while counting during shift count. -The Lorazepam tablets were halved and they were in a bottle instead of a bubble card so it was easy to drop them when pouring them out to count or putting them back in the bottle. -She did a shift count of the controlled substances with a second MA on Sunday, 10/07/18 on second shift and there were 46 half tablets of Lorazepam 1mg at that time. -She worked all of second shift as the only MA in the special care unit. -No one else had access to the medication cart. -On third shift, a third MA came in and that MA counted the controlled substances for the shift count. -She usually watched and counted together when they did shift counts but she was busy doing something and had her back to the other MA while that MA was counting. -She heard the other MA say there were only 43 Lorazepam tablets so she told the MA to count again. -The other MA counted a second time and got 43 tablets again. -She then turned around and counted a third time with the other MA and there were only 43 tablets but the CS log showed a balance of 46.	D 392		

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-They checked the floor and all around but could not find the 3 missing tablets.
-The resident had never needed the Lorazepam to be administered while she was working.
-She called the Resident Care Coordinator (RCC) and told her the count was off.
-The RCC told her to put a note on the RCC's desk and the RCC would check it on Monday, 10/08/18.
-There had never been any other discrepancies with the controlled substances to her knowledge.

Interview with a second MA on 10/12/18 at 2:45pm revealed:
-She and another MA counted Resident #5's Lorazepam during shift change on 10/07/18 and there were 46 tablets.
-She got a call later that same night from the other MA asking how many tablets they counted earlier that day.
-She told the other MA there were 46 tablets when they changed shifts.
-The other MA told her there were only 43 tablets now instead of 46.
-There had never been any discrepancies with the controlled substances when she did shift counts.

Attempted interview with the third shift MA on 10/12/18 at 3:07pm was unsuccessful.

Interview with the RCC on 10/12/18 at 1:10pm revealed:
-She was contacted by a MA on Sunday, 10/07/18, who reported there were 43 Lorazepam tablets for Resident #5 instead of 46.
-On Monday, 10/08/18, they started investigating the missing pills.
-She was not aware the second shift MA and the third shift MA did not count the controlled

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substances together on 10/07/18.
-The MAs were supposed to always watch each other and count the controlled substances together.
-The staff on duty that day would be required to take urine drug screenings and some had already been completed.
-The third shift MA had not been back on duty since 10/07/18.
-No other discrepancies with controlled substances had been reported to her.

Interview with the Administrator-in-Training (AIT) on 10/12/18 at 4:15pm revealed:
-It was brought to her attention on Monday, 10/08/18, that there were some missing Lorazepam tablets for Resident #5.
-The MAs counted the Lorazepam during shift change over the weekend and discovered there were 43 tablets in the bottle instead of 46 as indicated on the CS log.
-The Resident Care Coordinator (RCC) counted the Lorazepam tablets on Monday, 10/08/18 and the Regional Nurse counted the tablets on Tuesday, 10/09/18.
-The Regional Nurse did a MAR review and 3 Lorazepam tablets were unaccounted for.
-She completed a 24-hour report and called local law enforcement.

Review of Resident #5's incident/accident report dated 10/10/18 revealed:
-It was reported to the Administrator-in-Training (AIT) that 3 narcotics could not be accounted for on 10/08/18.
-The Regional Nurse reviewed the MAR to see if the medications could be accounted for.
-On 10/09/18, the Regional Nurse reported the missing pills could not be accounted for and needed to be reported as diversion.

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-An investigation was opened per facility's policy and procedure.

Review of a 24-hour initial report to the health care personnel registry (HCPR) dated 10/10/18 revealed:
-The facility reported diversion of drugs to the HCPR on 10/10/18.
-The incident date was 10/07/18 and time was unknown.
-It was reported on 10/09/18 that 3 doses of a narcotic for Resident #5 could not be accounted for.
-The accused individual was unknown.
-It was reported to the police on 10/10/18.

Telephone interview with a pharmacy technician at the primary pharmacy on 10/12/18 at 4:08pm revealed:
-The facility's Regional Nurse contacted the pharmacy today, 10/12/18, and reported 3 Lorazepam tablets were missing.
-The Lorazepam tablets were not dispensed by their pharmacy.
-There had been no reports of any missing pills from the facility prior to today.

2. Review of Resident #3's current FL-2 dated 04/10/18 revealed there was an order for Tramadol 50mg take 1 tablet every 6 hours as needed. (Tramadol is a controlled substance used to treat moderate to severe pain.)

Review of Resident #3's subsequent physician's order dated 06/27/18 revealed an order for Tramadol 50mg take 1 tablet every 8 hours as needed for pain.

Review of Resident #3's August 2018 - October 2018 medication administration records (MARs)

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revealed:
-There was an entry on each MAR for Tramadol 50mg take 1 tablet every 8 hours as needed for pain.
-Tramadol was documented as administered 40 times from 08/01/18 - 08/31/18.
-Tramadol was documented as administered 28 times from 09/01/18 - 09/30/18.
-Tramadol was documented as administered 5 times from 10/01/18 - 10/08/18.

Review of Resident #3's August 2018 - October 2018 controlled substance (CS) logs revealed:
-Tramadol was documented as administered 43 times from 08/01/18 - 08/31/18.
-Tramadol was documented as administered on 3 occasions that it was not documented on the MARs including: 08/08/18 at 2:17 (am or pm not specified), 08/10/18 at 3:43 (am or pm not specified), and 08/31/18 at 4:00am.
-Tramadol was documented as administered on 08/29/18 but documentation on the CS log was incomplete with no time specified.
-Tramadol was documented as administered 33 times from 09/01/18 - 09/30/18.
-Tramadol was documented as administered on 5 occasions that it was not documented on the MARs including: 09/12/18 at 8:55am, 09/18/18 at 10:45 (am or pm not specified), 09/26/18 at 5:45am and 3:00pm, 09/28/18 at 1:37pm, and 09/29/18 at 10:00am.
-Tramadol was documented as administered on 09/12/18 but documentation on the CS log was incomplete with no time specified.
-The CS log did not match and accurately reflect documentation on the MARs.
-The balance on hand of the Tramadol was noted to be 17 tablets on 10/12/18.

Observation of Resident #3's medications on

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D 392	Continued From page 21 10/12/18 at 12:32 pm revealed there were 17 Tramadol 50mg tablets on hand. Interview with Resident #3 on 10/10/18 at 10:16am revealed: -She took "a lot" of medications. -She took medication for arthritis pain. -She did not recall missing any doses of pain medication. Interview with a medication aide (MA) on 10/12/18 at 12:42pm revealed: -The MAs were supposed to document administration of controlled substances on the MARs and on the CS logs. -She did not know why the documentation for Resident #3's Tramadol on the CS log did not match the MARs. Interview with the Regional Nurse on 10/12/18 at 4:34pm revealed: -The MAs had been trained to document the administration of controlled substances on the MARs and the CS logs. -The CS logs and the MARs should match.	D 392		