

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675997	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER Carillon Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 A Norfolk Ave Lubbock, TX 79416	

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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49154</p> <p>Based on interview and record review the facility failed to provide pharmaceutical services that assured the accurate acquiring, receiving, dispensing, and administering of all medications to meet the needs of the residents and establishes a system of records of receipt and disposition of all drugs in sufficient detail to enable an accurate reconciliation for 1 of 1 resident reviewed for pharmaceutical services in that:</p> <p>The facility failed to have a system in place to ensure proper storage of medications that would prevent missing medications for Resident #1.</p> <p>This failure could place residents at risk of having their medications diverted and/or receiving the incorrect dosage because of improper storage.</p> <p>Findings included:</p> <p>Record review of Resident #1's face sheet dated [DATE], revealed Resident #1 was a [AGE] year-old male who was admitted to the facility on [DATE] with the following diagnoses: Malignant Neoplasm of spinal cord (cancerous tumors on the spinal cord), malignant neoplasm of brain, unspecified (tumors on the brain), benign prostatic hyperplasia with lower urinary tract symptoms (enlarged prostate gland that could make urination difficult). The face sheet further revealed Resident #1 was discharged to a hospital on [DATE] at 0020 (12:20) AM.</p> <p>Record review of Resident #1's orders, dated [DATE], revealed an active order for Morphine Sulfate oral tablet 30 MG (Opioid medication used to treat severe pain), every 3 hours as needed for pain; Start date [DATE].</p> <p>Record review of Resident #1's Medication Administration Record dated [DATE]-[DATE], revealed an active order for Morphine Sulfate oral tablet 30 MG; give by mouth every 3 hours as needed for pain; Start date [DATE]. The MAR further revealed Resident #1 received the medication on the following days: (,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], and [DATE]).</p> <p>Record review of the pharmacy shipment summary for Resident #1, dated [DATE], revealed the facility received an order on [DATE] at 19:29:47 (7:29 PM) for Morphine Sulfate IR (Immediate release) 30 MG Tablet quantity of 60.</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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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] 8:20 AM, the ADM stated he was notified on [DATE] that LVN A noticed a card of Morphine 30 ML PRN tablets and the narcotic sheet for a deceased resident (Resident #1) were missing from the medication cart after she took the keys and responsibility for the cart from LVN B. The ADM stated LVN B had already left the facility and was contacted by NM A to return to the facility but LVN B said she was too far and asked if she could return later. The ADM stated LVN A was immediately sent for a drug test and was negative for all substances. The ADM stated LVN B was also asked to take a drug test but he did not believe she went as she was employed by an agency and was not permanently employed by the facility. The ADM stated he contacted the agency to notify them of the situation and was told LVN B was terminated. He stated LVN B would no longer be able to work at the facility. The ADM stated LVN A gave a statement of the incident and said she counted the cart with LVN B on the morning of [DATE] before LVN B left for the shift and she took responsibility for the cart. The ADM stated he had looked for the missing medications and was not able to locate it. The ADM stated Resident #1 did not return to the facility as he passed away at the hospital.</p> <p>Record review of letter signed by LVN A on [DATE] revealed: On Friday morning [DATE], I came to work and got report from an agency nurse. Counted the narc cart down and noticed there were cards on the left side with the count cards wrapped around them. Asked the off going nurse what those were, she stated those are that man that passed away. I counted them and wrapped them back up with the cards and rubber band. Moved my cart to the family room area and began to pass meds. Went to pull narcs out of the book for a resident with the same last initial when I noticed that something did not look right. I looked through my cart thoroughly when it finally dawned on me that Resident #1's PRN Morphine 30 MG tablets were missing along with the count sheet. I called my nurse manager and informed her and looked through the med room cart and pretty much everywhere I could have thought they might have gotten misplaced.</p> <p>Record review of letter signed by LVN A on [DATE] revealed: Counted cart down on Wednesday night and was accounted for 30 milligrams PRN Morphine Thursday morning and evening meds were there as well. Counted Friday and as I stated earlier, I noticed them missing around 7:15 AM to 7:30 AM Friday morning when I notified nurse manager.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 2:04 PM, LVN A stated she worked the 7:00 AM-7:00 PM shift. She stated she recalled counting the card of Morphine 30 MG for Resident #1 when arriving and leaving for her previous shifts on [DATE] and [DATE]. She stated she arrived for her 7:00 AM shift on Friday, [DATE] and counted the medication cart with LVN B who was leaving for her shift as they were trained to do. She stated she noticed there were medication cards separated and wrapped in the narcotics sheets and asked LVN B about them. She stated LVN B told her they belonged to the male resident that passed away (Resident #1). She stated she explained to LVN B that they must count all medications in the cart and LVN B told her she did not know that but would remember for next time. LVN A stated she and LVN B counted the medications on the medication cart and both agreed all medications had been accounted for and both signed the medication cart count log. She stated she took the keys to the medication cart and possession of the cart at that time. She stated LVN B left the facility. LVN A stated she got her blood pressure cuff ready and began to pull medications to pass out to residents when she realized the medication was missing. She stated she did not catch the missing medication during the process of counting medications with LVN B because the medication card and narcotics sheet were both missing. LVN A stated she immediately called NM A to report the missing medication who then reported it to the Interim DON. She stated they all looked for the medication and narcotics log sheet in both medication carts, in the medication destruction box, in the medication destruction cabinet, and in the sharps collection container and did not locate it. She stated she was sent for a drug test and completed it. She stated she did not know what happened to LVN B. She stated NM A may have called LVN B to return to the facility but LVN B told her she was too far out of town. She stated she had never had this happen before. She stated NM A and the ADON were responsible to remove discontinued medication and medication from discharged residents from the medication carts but was not sure how often they were required to do that.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 10:45 AM, NM A stated LVN A called her on [DATE] at 7:21 AM and notified her that there was a narcotics sheet and a whole card of Morphine 30ML missing from the medication cart from Resident #1's medication supply. NM A stated LVN A told her she recalled she counted them the night before ([DATE]) with LVN B. She stated LVN A told her the reason she realized the medication was missing was because when she opened the drawer, she noticed two cards of Resident #1's medications were pulled aside and were wrapped in the narcotic sheets and tied with a rubber band. She stated LVN A told her she asked LVN B why those cards were pulled asked and wrapped like that and that LVN B told her those medications belonged to the deceased resident (Resident #1). She stated LVN A stated she told LVN B that those medications still needed to be counted with all the other medications in the cart so they counted the meds, and LVN B left for the day. NM A stated LVN A told her that afterwards she remembered that Resident #1 had three cards of medications in the cart and went back to check and that was when she discovered the card of Morphine 30 MG pills were missing and reported it to her. She stated she called LVN B and asked her to come back to the facility at about 7:45 AM and explained to her that she needed to return to the facility because there was a whole card of missing narcotics and LVN B told her she was an hour out of town. NM A stated she told LVN B she would check on it and call her back. She stated then LVN B texted her at 7:53 AM and asked if she could come back later that night, as she was coming back to town to work at another facility but that she needed to go to sleep. NM A stated she checked the pharmacy records to see what had been filled and determined the facility received the prescription on [DATE] and that that card had 60 pills. She stated the MAR indicated Resident #1 had only taken ten or eleven of those pills. NM A stated she reported the incident to the ADM and the Interim DON and they all searched for the pills and did not find them. She stated she also went to the Medical Records department to see if they had taken the narcotic sheet but did not locate it. She stated she called LVN C who was the regular night nurse and told her he last saw the medication in the medication cart on the night of [DATE]-[DATE], when he sent Resident #1 to the hospital. NM A stated no one else would have had access to that medication cart during that shift besides LVN B because she was the only nurse working on that shift along with two CNA's. She stated CNA's did not have keys to the medication carts. NM A stated Resident #1 went to the hospital on [DATE] and passed away on [DATE]. She stated they place a bed hold for 3 days when a resident discharges and during that time the medications were also left in the medication cart. She stated she was responsible to remove discontinued medications and medications that belonged to residents that discharged from the medication cart. NM A stated she should have removed the medications that belonged to Resident #1 from the medication cart on [DATE] when he passed away but did not know why she did not. She stated a potential negative outcome of medications not being removed timely was that they could be stolen by someone. She stated medications were supposed to be removed from the cart when residents discharged or when they pass away. She stated she should have taken them out of the cart. She stated the ADM asked her why she did not remove the medications from the cart but she did not know why and was not able to provide an answer to him.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 2:21 PM, LVN C stated he usually worked the night shift from 7:00 PM-7:00 AM. He stated he worked the night shift on [DATE], which was the night Resident #1 was sent to the hospital. He stated he was trained to always count the medications on the medication cart when arriving and leaving his shifts with the nurse he received the cart from and passed the cart to. He stated he recalled seeing Resident #1's Morphine 30 MG when leaving his shift at 7:00 AM. He stated he thought he passed the medication cart to LVN A that morning. He stated he was off work the next two days and learned Resident #1 passed away at the hospital when he returned to work on [DATE]. LVN C stated the reason he recalled seeing that medication on the Tuesday-Wednesday night was because he had to move Resident #1 to another room that night due to there being an issue with his bedroom heater and he also recalled Resident #1 was acting odd. He stated Resident #1 could have received that medication at 12:00 AM but he did not give it to him because Resident #1 did not complain of pain and then shortly after, Resident #1 was sent to the hospital due to being lethargic and he appeared to be declining. He stated he also recalled giving the medication to Resident #1 the night before. LVN C stated Resident #1 passed away the next day ([DATE]). LVN C stated he did not know which nurse worked the night shift on Wednesday and Thursday night. He stated he was told about the medication being missing when he returned to work on Friday.</p> <p>During an interview on [DATE] at 5:07 PM, LVN B stated she was employed through an Agency and worked at the facility on days she was assigned to work there. LVN B stated she last worked at the facility last week. LVN B stated she received a call from NM A on [DATE] who told her there was a medication missing from the medication cart and did not get signed out. LVN B stated NM A asked her if she remembered what medication was in the cart. LVN B stated she told NM A that she put aside the medications that belonged to the deceased resident that was in the hospital. LVN B stated she asked NM A if she could go back tomorrow because she lived in another state and 1.5 hours away. LVN B stated NM A replied she would call her back and never heard back from NM A. LVN B stated she told NM A that all the medication was there when she counted it with LVN A. She stated LVN A did not say anything to her about there being missing medication, so as far as she knew, it was correct, and then LVN A took the keys and medication cart from her. LVN B stated she went home after they signed the logbook. LVN B stated she was trained to pull medications that belonged to discharged residents and wrap the narcotic sheet around the card with a rubber band and put it at the back of the narcotics drawer. She stated there were two medication cards she wrapped that belonged to Resident #1 and she put them in the back of the drawer. She stated she had not been assigned to work at the facility since then. She stated the facility reported her to the agency she worked for and they ended her employment. She stated she explained to the agency that she and LVN A counted the medication cart before she left the facility like they were trained and that the count was correct and LVN A took possession of the cart. LVN B stated she would never take a medication cart from another nurse if the medication cart was wrong. LVN B stated had possession of two medication carts that night. She stated she did not know the exact name of the medication that was missing.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 11:45 AM, the Interim DON stated she staff were trained to lock medication carts and the monitor that displays the medication administration record every time they walk away from them. She stated staff should never leave a medication cart unlocked. She stated the off going and oncoming nurse must count the narcotics in the medication carts together when changing shifts and/or exchanging the cart. She stated staff must reach out to the nurse manager, the ADON, and to the Interim DON when there was a discrepancy on the count of the narcotics. The interim DON stated she did not know what the policy for removing discontinued medications and medications that belonged to discharged residents from the medication carts. She stated she did not know who was responsible for removing those medications from the medication carts. She stated she was made aware that a card of Morphine 30 MG tablets was missing from the medication cart on Friday ([DATE]) by NM A. The Interim DON stated she thought the medication was discovered to be missing when staff were in the process of removing discontinued and medications that belonged to discharged residents from the medication cart. She stated she was working on developing a new protocol to remove medications from those two categories from the medication carts within 24 hours, but she did not know what the system was prior. She stated she was not aware of a system in place to ensure missing medications did not go unnoticed when the narcotic sheet and the whole medication card was gone. The Interim DON stated staff received ongoing training from the ADM, the DON, and the nurse educator. She stated she was not sure if staff received training on PRN medications. She stated she was not sure who was responsible to ensure the medication count was correct before exchanging a medication cart with another staff. She stated she expected staff to ensure the medications were counted correctly and all medications were accounted for before passing on the cart. She stated it was okay for LVN B to go home for the day once she and LVN A agreed the count was correct and both signed the medication count log. The Interim DON stated a potential negative outcome of Resident #1's Morphine being taken could have been that he would not have received this medication and his pain would not have been addressed appropriately.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 12:04 PM, the ADM stated they were not able to locate Resident #1's Morphine. He stated staff must lock the medication carts anytime they were not using it and anytime they did not have their eyes not on the cart. The ADM stated both the oncoming and off going staff were trained to count all narcotics in the medication carts and compare the number amount of medication counted to the narcotic log sheet. The ADM stated if the numbers did not match, then this must be reported and investigated immediately. He stated the narcotics were double locked on the cart. He stated only the charge nurse on the shift had access to the medication carts and the keys to them. He stated there was only one set of keys to each medication cart. He stated discontinued medications and medications that belonged to discharged residents should be removed from the medication carts immediately but not later than three days afterwards. The ADM stated the ADON was the only person that had access to the drug destruction bin besides the consultant pharmacist. The ADM stated the DON was responsible to ensure all discontinued medications and medications that belonged to discharged residents were accounted for and destroyed properly. He stated the ADON and NM A were responsible to ensure all medication carts were free and clean of discontinued medications and medications that belonged to discharged residents. He stated he was not aware that Resident #1's medication was missing until he was notified the morning of [DATE]. He stated both the oncoming and off going staff were responsible to ensure the medication count was verified and correct. He stated the oncoming staff should ensure the cart was correct before accepting a cart and the off going staff was responsible to ensure the medication count was correct. He stated he expected staff to ensure the medication count was correct. He stated it was technically okay for LVN B to go home once she and LVN A agreed the medication count was correct and LVN A took the keys and accepted the cart. The ADM stated the pharmacist would have discovered Resident #1's medication to be missing during their monthly rounds of audits on all medications however there was no other system in place to catch missing medications from the carts when both the narcotic sheet and the medication card were missing besides those audits. He stated staff were trained on PRN medications and narcotic medications after this incident. The ADM stated a potential negative outcome could have been that Resident #1 would not have had access to the care he needed to manage his pain as Morphine was typically prescribed to resident's that had chronic pain. The ADM stated Resident #1 had chronic pain related to cancer. The ADM stated however, the missing medication did not affect Resident #since he passed away at the hospital and did not return to the facility. He stated Resident #1 received the medication during the time he was at the facility. The ADM stated another potential negative outcome was that the diversion would go unnoticed and residents would be short of the medication they needed to maintain their pain free life.</p> <p>Record Review of the facility provided policy, Discarding and Destroying Medications, undated, revealed in part: Policy Statement: The facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications.</p> <p>Policy Interpretation and Implementation</p> <p>12. At the End of Each Shift:</p> <p>a. Controlled medications are counted at the end of each shift. The nurse coming on duty and the nurse going off duty determine the count together.</p> <p>b. Any discrepancies in the controlled substance count are documented and reported to the director of nursing services immediately.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>49154</p> <p>Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals were stored in locked compartments for 2 of 6 medication carts (Cart 4S1 and Cart 4S2) observed in the facility.</p> <p>The facility failed to ensure medication cart 4S1 and medication cart 4S2 on the fourth floor were secured when unattended on 2/25/25.</p> <p>This failure could place residents at risk of having access to unauthorized medications and/or lead to possible harm, drug overdose, or drug diversion.</p> <p>Findings included:</p> <p>During an observation and interview on 2/25/25 at 2:18 PM medication carts 4S1 and 4S2 were observed in the 4th floor dining area with the locks popped out on both medication carts. RN A was observed walking towards from a hallway on the other side of the floor. RN A approached the medication carts and stated she was the charge nurse on the floor and was assigned to both medication carts. RN A pulled on all the drawers and all of drawers opened except the drawer that narcotic medications were stored in. Various cards and bottles of medications and medical supplies were observed in the drawers of the medication carts that opened.</p> <p>During an interview on 2/25/25 at 2:19 PM, RN A stated she was in the process of passing medications from two medication carts and she left both medication carts (Cart 4S1 and Cart 4S2) unlocked. RN A stated she received in-service trainings on PRN medications and drug diversion a week or two ago. RN A stated she was coming from a resident's room that she was administering a covid test and wound care on. She stated she was trained to lock the medication cart every time she was not standing in front of it. RN A stated a potential negative outcome was that someone could take medications and anything else that was in the cart and then residents would no longer have their medications they needed. She stated she was not aware she left the carts unlocked. She stated she did not think about it in that moment. She stated she was responsible to ensure medication carts were locked.</p> <p>During an interview on 2/28/25 at 11:45 AM, the Interim DON stated she staff were trained to lock medication carts and the monitor that displays the medication administration record every time they walk away from them. She stated staff should never leave a medication cart unlocked. The Interim DON stated she was not aware nurses were leaving medication carts unlocked while unattended. She stated the system for ensuring carts were not left unlocked was to educate the staff. The Interim DON stated staff received ongoing training from the ADM, the DON, and the nurse educator. She stated she did not know the last time staff were trained on locking the medication carts. She stated the nurse that had possession of the medication cart was responsible to ensure it was locked. She stated she expected staff to lock unattended carts. The Interim DON stated a potential negative outcome of medication carts being left unlocked while unattended was that medications could be taken from the cart which would then cause the residents to not get the medications they need.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/28/25 at 12:04 PM, the ADM stated staff must lock the medication carts anytime they were not using it and anytime they did not have their eyes not on the cart. He stated the narcotics were double locked on the cart. He stated only the charge nurse on the shift had access to the medication carts and the keys to them. He stated there was only one set of keys to each medication cart. He stated he was not aware nurses were leaving medication carts unlocked and unattended. He stated staff were trained by the NM A to not leave medication carts unlocked and they also talk with staff about it regularly during rounds. He stated he expected staff to lock the medication cart. The ADM stated a potential negative outcome of leaving a medication cart unlocked was that residents could access carts and take something or resident's medications could be misappropriated by staff or visitors. The ADM stated it could cause a resident to be affected financially because their property would be stolen and they may not have enough medication to last them through the number of days they were expected to. The ADM stated another potential negative outcome was that the diversion would go unnoticed and residents would be short of the medication they needed to maintain their pain free life.</p> <p>Record Review of the facility provided policy, Administering Medications, undated, revealed in part: Policy heading: Medications are administered in a safe and timely manner, and as prescribed.</p> <p>Policy Interpretation and Implementation</p> <p>19. During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide. It may be kept in the doorway of the resident's room, with open drawers facing inward and all other sides closed. No medications are kept on top of the cart. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by.</p>		