



## **ASSISTED LIVING SERIOUS VIOLATIONS WITH ENFORCEMENT (Misappropriation – Prescription Medications)**

Division of Quality Assurance

P-00427 (11/2012)

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The Division of Quality Assurance (DQA) maintains information about violations that are issued and sanctions that are imposed, which may include forfeitures against state-licensed, certified, and registered assisted living facilities. This report does not include all information contained in a particular survey report or in corresponding documents, and may not reflect changes that occur as a result of the appeal process or due to administrative changes. DQA protects the confidentiality of residents as required by law and no conclusions should be drawn based on the content in the report about the identity of any individual.

1. Steps were not taken to promptly replace a resident's narcotic pain medication after 30 pills were stolen. The facility had not submitted a report to the Department and had not contacted law enforcement. After the resident was without pain medication for six days, the resident's family notified the police in an effort to authorize a replacement supply of the medication. (CBRF)
2. A caregiver witnessed a co-worker slipping a resident's narcotic pain medication into her pocket. Another caregiver witnessed the co-worker putting a resident's medication "in her own mouth" during a medication pass. The incidents were reported to the manager but no investigation was conducted and the co-worker remained on the work schedule, assigned to administer medications. (CBRF)
3. The licensee refilled and stole 50 bottles of narcotic pain medication prescribed for a resident with developmental disabilities who was unable to communicate. When investigated by law enforcement, the licensee confessed that she had never given the pain medication to the resident in the 8 years she provided care. (AFH)
4. A resident had a prescription for Oxycodone to treat pain. Compartments in the unit dose package had been cut open and the narcotic had been replaced with over-the-counter Tylenol. Documentation indicated prn (as needed) medications were administered during the night shift when residents were sleeping and had not requested medication. Employee drug testing was conducted and a caregiver on the night shift tested positive and was terminated. (CBRF)
5. The facility did not complete a criminal background check for an employee with illegal drug convictions. The new employee was assigned to administer medications to residents, including narcotic pain medications. A complainant alleged that medications, for which the employee was responsible, turned up missing. No facility investigation occurred. (CBRF)
6. A caregiver who had been convicted in the past of stealing controlled substances was hired as a facility manager. The caregiver admitted taking narcotic pain medications (more than 3,700 doses) that had been prescribed to residents. (CBRF)
7. A facility manager hired her boyfriend to work at the facility and did not conduct a criminal background check. After he stole 50 doses of narcotic pain medication from a resident, it was discovered that he had a conviction record that included battery and possession of drugs. (CBRF)
8. A facility identified that more than 20 tablets of Lorazepam (an anti-anxiety medication) were missing. The facility did not notify the resident's legal guardian of the theft. (CBRF)

9. A caregiver stole medications from two residents. The facility failed to report the caregiver as required. The same caregiver was later investigated for stealing medications (59 Oxycodone) at a different facility and received a substantiated finding on the caregiver registry. (CBRF)
10. A facility did not investigate two allegations of stolen prescription medications and did not report either allegation to the Department, thereby placing other residents at risk. (CBRF)
11. The facility did not investigate upon learning there were 30 tablets of anti-depressant medication missing. (CBRF)
12. The police were called to a facility to investigate allegations that a caregiver was intoxicated and in control of the residents' medications. The caregiver could not account for medication that was missing and an arrest was made. (CBRF)
13. Prescribed medications were missing but an investigation was not conducted because the manager stated that staff were too busy. (CBRF)
14. A caregiver falsely documented that she was administering multiple doses of "as needed" narcotic pain medication to a resident. The caregiver was terminated for the theft of narcotic medication and for altering medical records. (CBRF)
15. The Department received a complaint that a resident was missing 40 or more Oxycodone tablets. The facility was aware of the theft and had not notified the police. (CBRF)
16. A facility did not investigate and report to the department when a resident's Fentanyl patches (prescribed for pain management) were missing. (CBRF)
17. A facility discovered prescription pain medications (more than 30 pills) belonging to two residents had been stolen and medication records (pharmacy delivery sheets, medication administration records, audit reports) were taken also. (CBRF)
18. Medication and money were stolen from residents, including over 140 pills. One resident had resided in the facility for 15 years but was transferred to another facility by his/her legal guardian due to concerns about alleged theft by caregivers. (CBRF)
19. The facility did not report the diversion or tampering of a hospice resident's Morphine Sulfate to law enforcement. The hospice nurse noticed the Morphine Sulfate bottle was not the usual color and had been replaced by a different substance. The nurse reported this to the facility administrator, but police were not contacted. (CBRF)