

PRINTED: 12/15/2022
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL017052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 11/23/2022
NAME OF PROVIDER OR SUPPLIER HUMPHREY FAMILY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 6245 BURTON CHAPEL ROAD MEBANE, NC 27302	
(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)
C000	Initial Comments The Adult Licensure Section conducted an annual survey, a follow-up survey and a complaint investigation on November 22, 2022 to November 23, 2022	C000	
C246	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure referral and follow-up to meet the routine health care needs for 1 of 3 sampled residents (#3) related to referrals for appointments for a mammogram and a colonoscopy. The findings are: Review of Resident #3 's current FL2 dated 05/06/22 revealed diagnoses included bipolar, aggression, intellectual disability and hypertension. a. Review of a after visit summary from Resident #3's primary care provider (PCP) dated 06/06/22 revealed there was an order for a mammogram. Review of Resident #3 's record on 11/23/22 revealed: -There was no documentation of an appointment for a mammogram for Resident #3. -There were no documented results from a mammogram, or documentation a mammogram was done.	C246	Effective 12/01/2022 Administrator created a LOG to document all appointments and will train staff immediately to document all appointments to ensure the safety of the residents are kept to ensure referral and follow-up appointments are met and routine acute health care needs for all residents are met. Administrator, to monitor this policy for the next 6 months weekly then this responsibly with be transferred to the SIC and Administrator to monitor monthly. Provider notified and is rescheduling appointments that were missed. Training will be provided for current and future staff on Referral and Appointment Documentation!

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6899

1ZDW11

If continuation sheet 1 of 16

Reviewed and acknowledged on 01/13/22.

P.D.

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C246	Continued From page 1 Interview with Resident #3 on 11/23/22 at 11:02am revealed: -She had not had a mammogram this year, 2022. -No one told her she needed a mammogram. Interview with a representative from the facility's contracted PCP's office on 11/23/22 at 12:18pm revealed she could not find any documentation for a mammogram for Resident #3. Interview with a medication aide (MA) on 11/22/22 at 4:53pm revealed: -She did not schedule appointments for the residents. -She thought the Assistant Administrator scheduled appointments for the residents. -The Assistant Administrator would tell her when a resident had an appointment. -She did not know if Resident #3 had a mammogram done. Interview with the Assistant Administrator on 11/23/22 at 12:37pm revealed: -She thought Resident #3 had a mammogram sometime during the summer of 2022, but she could not remember when. -There was a mobile mammogram that came to the facility to conduct the mammogram. -There should have been documentation of the mammogram in Resident #3's record. -The MAs were responsible for scheduling the residents' appointments and following-up with the PCP to be sure the appointments were made. Attempted telephone interview with a second MA on 11/23/22 at 12:06pm was unsuccessful. b. Review of an after-visit summary from Resident #3's primary care provider (PCP) dated 06/06/22 revealed an order for a colonoscopy.	C246		

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C246	Continued From page 2 Review of Resident #3 's record on 11/23/22 revealed: -There was no documentation of an appointment for a colonoscopy for Resident #3. -There were no documented results from a colonoscopy, or documentation a colonoscopy was done. Interview with Resident #3 on 11/23/22 at 11:02am revealed: -She had not had a colonoscopy this year, 2022; she did not remember preparing for a colonoscopy. -No one told her she needed a mammogram. Interview with a representative from the facility's contracted PCP's office on 11/23/22 at 12:18pm revealed she could not find any documentation Resident #3 had a mammogram.	C246		
C273	10A NCAC 13G .0904(d)(3)(A) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (d) Food Requirements in Family Care Homes: (3) Daily menus for regular diets shall include the following: (A) Homogenized whole milk, low fat milk, skim milk or buttermilk: One cup (8 ounces) of pasteurized milk at least twice a day. Reconstituted dry milk or diluted evaporated milk may be used in cooking only and not for drinking purposes due to risk of bacterial contamination. This Rule is not met as evidenced by: C 273 Based on observations, record reviews, and	C273	Effective immediately Administrator / SIC will monitor staff daily to ensure that the menu is being followed and that milk is offered at least twice a day. Two servings of fruit (one serving equals 6 ounces of juice, ½ cup raw, canned or cooked fruit; 1 medium-size whole fruit; or ¼ cup dried fruit). One serving shall be a citrus fruit or a single strength juice in which there is 100% of the recommended dietary allowance of vitamin C in each six ounces of juice. The second fruit serving shall be of another variety of fresh, dried or canned fruit. Administrator / SIC to monitor meal servings for 6 weeks then continue with meal reviews bi-monthly with SIC and staff.	12/01/2022

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C273	Continued From page 3 interviews, the facility failed to ensure 8 ounces of milk was served to the residents twice daily. The findings are: Observation of the kitchen on 11/22/22 at 9:02am revealed: -There was a pitcher of with approximately one cup of milk in the refrigerator. -There was no other milk in the refrigerator. Observation of the lunch meal on 11/22/22 at 12:35pm revealed the residents were served water and canned sodas with their meals; milk was not offered. Observation of the dinner meal on 11/22/22 at 4:45pm revealed water and canned soda was served to the residents; milk was not offered to the residents. Interview with two residents on 11/22/22 at 4:21pm revealed: -They were not offered milk to drink with their meals or at snack times. -They were served canned milk with water added to it. -One resident saw staff mix together canned milk and water in a pitcher and pour it into her cereal. -Another resident was offered the same canned milk mixed with water to drink. -They did not like the canned milk to drink or to add to their cereal. -If there was fresh milk, they would drink milk more often. Interview with the medication aide (MA) on 11/22/22 at 8:57am revealed: -She only served coffee or water to the residents. -None of the residents wanted milk so she did not	C273		

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C273	Continued From page 4 serve it; she had asked the residents if they wanted milk to drink. -The residents did not ask for milk. -Water had been added to the canned milk and placed in the pitcher. -She did not serve the canned milk that was in the pitcher; she only used it for cooking. -She had not had milk for over two days. -The Assistant Administrator brought groceries to the facility about once a week. -She was expecting a grocery delivery that day, 11/22/22. -She called the Assistant Administrator and gave her a list of food she needed for the week. -She knew milk was on the menu for lunch and dinner. Interview with the Assistant Administrator on 11/23/22 at 12:37pm revealed: -She delivered groceries once a week to the facility. -The MA called her and gave her a list of food that was needed. -She would deliver a gallon of milk once a week, but it always expired and go bad before it was used. -She had started to provide evaporated milk about two months ago for the staff to use when they cooked or when the residents wanted milk to drink. -She knew one of the residents complained only canned milk was available to drink. -When she provided the fresh milk the resident that complained would not drink it. -She did not know canned milk could only be used for cooking and not for the residents to drink.	C273		

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C330	Continued From page 5	C330	Immediately Administrator / SIC will train on duty staff on how to use the glucometer, sliding scale and insulin. Administrator / SIC will train all staff within the next 14 days on administering insulin, the use of glucometer and the sliding scale insulin.	12/01/2022
C330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family 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 ensure medications were administered as ordered for 1 of 3 sampled residents (#1) including errors administering sliding scale insulin. The findings are: Review of Resident #1's current FL-2 dated 02/16/22 revealed diagnoses included mild intellectual disability, depression, uncontrolled type two diabetes with insulin therapy, and coronary artery disease (CAD). Review of Resident #1's physician orders dated 08/01/22 revealed there was an order for Humalog (a short acting medical insulin used to regulate blood sugars) inject three times daily with meals and at bedtime with finger stick blood sugar (FSBS) per sliding scale; 151-200 give 2 units, 201-250 give 4 units, 251-300 give 6 units, 301-350 give 8 units, 351-400 give 10 units. Review of Resident #1's lab results dated 09/20/22 revealed:	C330	Administrator / SIC will monitor staff, check logs to ensure insulin is being administered according to sliding scale. Administrator / SIC will educate all staff to ensure insulin is being administered according to sliding scale. Administrator / SIC will contact doctor if the blood sugar is over 400.	

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(X4) ID PREFIX TAG C330	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 6 -Resident #1's HgbA1c (an HgbA1c test is a blood test that reflects the average blood glucose level over the past three months) was 10.0 percent on 12/12/17 and decreased to 6.5 percent on 09/20/22. -An HgbA1c level of 6.4 percent indicates diabetes in adults. Review of Resident #1's September 2022 hand-written medication administration record (MAR) revealed: -There was an entry for test strips for FSBS four times daily scheduled at 8:00am, 12:00pm, 4:00pm and 5:00pm. -There was documentation the FSBS were completed four times daily but there were no FSBS results documented on the MAR. -There was an entry for Humalog three times daily with meals and once at bedtime administered per sliding scale; 151-200 give 2 units, 201-250 give 4 units, 251-300 give 6 units, 301-350 give 8 units, 351-400 give 10 units. -Humalog was scheduled four times daily at 8:00am, 12:00pm, 4:00pm and 5:00pm. -There was documentation Humalog was administered four times daily from 09/01/22 to 09/13/22 using initials but there were no FSBS results or the how many units of Humalog were administered per the sliding scale. -There was documentation Humalog was administered 16 times out of 64 opportunities from 09/14/22 to 09/30/22 using initials but there were no FSBS results or the how many units of Humalog were administered per the sliding scale documented. Review of Resident #1's October 2022 hand-written MAR revealed: -There was an entry for test strips for FSBS four times daily scheduled at 8:00am, 12:00pm,	ID PREFIX TAG C330	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE

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C330	Continued From page 7 4:00pm and 5:00pm. -There was documentation the FSBS were completed four times daily but there were no FSBS results documented on the MAR. -There was an entry for Humalog three times daily with meals and once at bedtime administered per sliding scale; 151-200 give 2 units, 201-250 give 4 units, 251-300 give 6 units, 301-350 give 8 units, 351-400 give 10 units. -Humalog was scheduled four times daily at 8:00am, 12:00pm, 4:00pm and 5:00pm. -There was documentation Humalog was administered 28 times out of 124 opportunities from 10/01/22 to 10/31/22 using initials, but there were no FSBS results or the how many units of Humalog were administered per the sliding scale documented. Review of Resident #1's November 2022 hand-written MAR revealed: -There was an entry for test strips for FSBS four times daily scheduled at 8:00am, 12:00pm, 4:00pm and 5:00pm. -There was documentation the FSBS were completed four times daily but there were no FSBS results documented on the MAR. -There was an entry for Humalog three times daily with meals and once at bedtime administered per sliding scale; 151-200 give 2 units, 201-250 give 4 units, 251-300 give 6 units, 301-350 give 8 units, 351-400 give 10 units. - Humalog was scheduled four times daily at 8:00am, 12:00pm, 4:00pm and 5:00pm. -There was documentation Humalog was administered 21 times out of 84 opportunities from 11/01/22 to 11/22/22 using initials, but there were no FSBS results or the how many units of Humalog were administered per the sliding scale documented.	C330		

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	Continued From page 8 Review of Resident #1's Blood Sugar Log for September 2022 revealed: -The log had Resident #1's name hand-written across the top. -There were four columns labeled date, time, level and notes. -There were FSBS results documented four times daily from 09/01/22 to 09/30/22; each result was initialed. -There was documentation beside each FSBS result in the notes column when Humalog insulin was administered per the sliding scale; each administration was initialed. -There were no errors in the amounts of Humalog administered per sliding scale for the month of September 2022. Review of Resident #1's Blood Sugar Log for October 2022 revealed: -The log had Resident #1's name hand-written across the top. -There were four columns labeled date, time, level and notes. -There were FSBS results documented four times daily from 10/01/22 to 10/31/22; each result was initialed. -There was documentation beside each FSBS result in the notes column when Humalog insulin was administered per the sliding scale; each administration was initialed. -On 10/06/22, the FSBS was documented as 201 at 12:00pm and 2 units of Humalog were documented as administered. -Per the sliding scale, 4 units of Humalog were to be administered for FSBS results of 201 to 250. -On 10/25/22, the FSBS was documented as 201 at 12:00pm and 2 units of Humalog were documented as administered. -Per the sliding scale, 4 units of Humalog were to be administered for FSBS results of 201 to 250.			

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	Continued From page 9 -On 10/31/22, the FSBS was documented as 206 at 12:00pm and 2 units of Humalog were documented as administered. -Per the sliding scale, 4 units of Humalog were to be administered for FSBS results of 201 to 250. Review of Resident #1's Blood Sugar Log for November 2022 revealed: -The log had Resident #1's name hand-written across the top. -There were four columns labeled date, time, level and notes. -There were FSBS results documented four times daily from 11/01/22 to 11/22/22; each result was initialed. -There was documentation beside each FSBS result in the notes column when Humalog insulin was administered per the sliding scale; each administration was initialed. -On 11/06/22, the FSBS was documented as 284 at 8:00pm and 4 units of Humalog were documented as administered. -Per the sliding scale, 6 units of Humalog were to be administered for FSBS results of 251 to 300. -On 11/10/22, the FSBS was documented as 231 at 12:00pm and 2 units of Humalog were documented as administered. -Per the sliding scale, 4 units of Humalog were to be administered for FSBS results of 201 to 250. -On 11/18/22, the FSBS was documented as 211 at 4:00pm and 2 units of Humalog were documented as administered. -Per the sliding scale, 4 units of Humalog were to be administered for FSBS results of 201 to 250. -On 11/13/22, there were no FSBS results documented and no documentation Humalog was administered at 4:00pm and 8:00pm. -On 11/14/22, there were no FSBS results documented and no documentation Humalog was administered at 8:00am and 12:00pm.			

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	Continued From page 10 Interview with Resident #1 on 11/22/22 at 4:11pm revealed: -She checked the Humalog units dialed on the pen before she injected it; the units were based on the FSBS results. -She knew what her sliding scale was for her Humalog because it was on the label on the box of Humalog pens. -She had been taught how to dial the correct units on the Humalog pen while in the hospital after she was diagnosed with diabetes. -She did not recall the units being incorrect when she looked at the pen. -There were times when she did not need to be administered any Humalog based on the sliding scale. -She did not recall missing a FSBS check or a Humalog administration if she needed it. Interview with the medication aide (MA) on 11/22/22 at 11:52am revealed: -She followed the sliding scale order Resident #1 that was on the MAR. -She documented the date, time, FSBS results and the units of Humalog administered and her initials on Resident #1's Blood Sugar Log. -She was careful when she documented on the MAR. -She had only been working at the facility for about seven days. -She did not know why Resident #1's Humalog was documented as administered incorrectly. -Resident #1 checked the units on she dialed on the Humalog pen prior to administering them. Interview with the Assistant Administrator on 11/23/22 at 1:15pm revealed: -When a resident had a sliding scale order the sliding scale should always be referenced before			

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C330	Continued From page11 administering insulin. -The FSBS results should be compared to the sliding scale to see the number of units that should be administered. -She audited the MARs and checked the Blood Sugar Logs about every other month. -She looked for holes and checked the sliding scale for accuracy when she did audits. -She had done an audit on Resident #1's MAR and Blood Sugar Logs at the beginning of November 2022. -When she did the audit, she did not any errors on Resident #1's Blood Sugar Logs for October 2022 and November 2022. -If a resident is administered the incorrect amount of insulin and it is realized when it was administered the resident's primary care provider (PCP) should be notified. -Resident #1 was aware of her sliding scale and how many units of Humalog she was supposed to be administered; she would have caught the incorrect Humalog units. -She thought maybe the MA administered the correct amount of Humalog but had documented the amount incorrectly on the log. Attempted telephone interview with a second MA on 11/23/22 at 12:06pm was unsuccessful. Attempted telephone interview with Resident #1's primary care provider (PCP) on 11/23/22 at 12:18pm was unsuccessful.	C330		
C371	10A NCAC 13G .1008 (e) Controlled Substances 10A NCAC 13G .1008 Controlled Substances e) Records of controlled substances returned to the pharmacy or destroyed by the facility shall be	C371		

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C371	Continued From page 12 maintained by the facility for a minimum of three years. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to maintain documentation for 1 of 1 resident's (#1) control substance. The findings are: Review of Resident #1's current FL-2 dated 02/16/22 revealed diagnoses included mild intellectual disability, depression, uncontrolled type two diabetes with insulin therapy, and coronary artery disease (CAD). Review of Resident #1's physician orders dated 08/01/22 revealed an order for tramadol (used to treat pain) 50mg take one tablet twice daily as needed (PRN) for pain. Review of Resident #1's September 2022 medication administration record (MAR) revealed: -There was an entry for tramadol 50mg one tablet twice daily PRN. -Tramadol 50mg was not documented as administered during the month of September 2022. Review of Resident #1's October 2022 MAR revealed: -There was an entry for tramadol 50mg one tablet twice daily PRN. -Tramadol 50mg was not documented as administered during the month of October 2022. Review of Resident #1's November 2022 MAR	C371	Effective immediately Administrator / SIC has instructed (MA) to verify count on all medicine administered to Resident #1 after every medication pass. Administrator / SIC will review medication for Resident #1 for 6 weeks with staff. Immediately the staff will count medication at the change of each shift, each employee will sign that the medication count is accurate. If the count is not correct the (MA) will immediately contact the Administrator / SIC. Administrator / SIC will contact all medication aides to re-educate on the correct procedure on how to document on the MAR. Effective immediately Administrator will schedule continued education on Medication Errors for current and future staff. Medication chart audits will be completed for all residents with all medications weekly by the Administrator / SIC for 6 weeks, and will continue with Medication reviews bi-monthly with SIC and staff.	12/01/2022

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
STATE FORM

6899

1ZDW11

TITLE

(X6) DATE

If continuation sheet 13 of 16

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL017052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 11/23/2022	
NAME OF PROVIDER OR SUPPLIER HUMPHREY FAMILY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 6245 BURTON CHAPEL ROAD MEBANE, NC 27302		
(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
C371	Continued From page 13 revealed: -There was an entry for tramadol 50mg one tablet twice daily PRN. -Tramadol 50mg was not documented as administered during the month of November 2022. Review of Resident #1's controlled substance count sheet (CSCS) for tramadol 50mg PRN revealed: -The CSCS was dated 02/16/22 -Fourteen tablets were dispensed. -The order was for tramadol 50mg one tablet twice daily PRN. -There were amounts or administration dates documented on the CSCS. Review of Resident #1's medications on hand on 12/22/22 at 12:59pm revealed there was no tramadol 50mg available to be administered. Telephone interview with a Pharmacist for the facility's contracted pharmacy on 11/22/22 at 2:53pm revealed: -Resident #1 had 14 tablets of tramadol 50mg dispensed to the facility on 02/16/22. -Tramadol had not been dispensed again for Resident #1. -There was a signature for the facility staff who received the tramadol when it was delivered to the facility. -There was no documentation the facility returned or requested a pickup for return of the tramadol. Interview with Resident #1 on 11/22/22 at 4:11pm revealed: -She had not needed to take the tramadol, so she never asked for it. -If she had pain she could ask for	C371		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL017052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 11/23/2022	
NAME OF PROVIDER OR SUPPLIER HUMPHREY FAMILY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 6245 BURTON CHAPEL ROAD MEBANE, NC 27302		
(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
C371	Continued From page 14 acetaminophen. Interview with a medication aide (MA) on 11/22/22 at 8:30am revealed: -She started working at the facility about seven days ago. -She had done a medication audit when she started. -She could not find Resident #1's tramadol or the CSCS. -She had asked the previous MA where they were. -The previous MA said she did not know and would ask the Assistant Administrator where the tramadol and the CSCS were. -She forgot to ask the Assistant Administrator about Resident #1's tramadol. -The CSCS was found in Resident #1's record on 11/22/22. Interview with the Assistant Administrator on 11/22/22 at 3:05pm revealed: -She recalled Resident #1's tramadol but thought it had been thirty tablets. -She did an audit of all the medication in the facility and sent the tramadol back with a group of other PRN medications that had not been used by residents. -She recalled sending Resident #1's tramadol back to the pharmacy sometime in June 2022. -Resident #1 had never requested or been administered the tramadol. -She requested the facility's contracted primary care physician (PCP) to discontinue the tramadol when she sent it back to the pharmacy. -The facility's PCP would not discontinue the tramadol because it required a new order for refill. -The PCP thought the tramadol would fall off the MAR. -She did not notify the pharmacy the group of	C371		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL017052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 11/23/2022	
NAME OF PROVIDER OR SUPPLIER HUMPHREY FAMILY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 6245 BURTON CHAPEL ROAD MEBANE, NC 27302		
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C371	Continued From page 15 medications were being returned including the tramadol. -She could not recall how many medications were returned. -She did not document the return of the tramadol. -She did not know she needed to keep documentation when she returned control substances to the pharmacy. -She did not keep documentation of medication deliveries from the pharmacy. -She could not explain why the pharmacy did not have documentation of tramadol being returned. -She did not have a concern or need to contact the Health Care Personnel Registry (HCPR) because she remembered sending the tramadol back to the pharmacy. Attempted telephone interview with Resident #1's PCP on 11/23/22 at 12:18pm was unsuccessful. Attempted telephone interview with a second MA on 11/23/22 at 12:06pm was unsuccessful.	C371		