

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL-092-22	(X2) MULTIPLE BUILDING STRUCTURE A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/05/2025
NAME OF PROVIDER OR SUPPLIER THE EAST TOWER AT CARDINAL NORTH HILLS		STREET ADDRESS, CITY, STATE, ZIP CODE 320 ST ALBANS DRIVE RALEIGH, NC 27609			
(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 annual survey and a follow up survey on February 4-5, 2025.	D 000	10A NCAC 13F .0311 (d) Other Requirements Measures to Correct the Deficient Area of Practice:		
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure water temperatures were maintained between 100 to 116 degrees Fahrenheit (F) in residents' bathrooms as evidenced by 6 of 7 fixtures with water temperatures ranging from 117.3 to 120.2 degrees Fahrenheit (F). The findings are: Review of the facility's census on 02/04/25 revealed there were 36 residents in the facility. Observation of the water temperatures in the facility on 02/04/25 from 9:40am to 10:30am revealed: -The hot water temperature in the bathroom sink in room 403 was 118.2 degrees Fahrenheit (F). -The hot water temperature in the bathroom sink	D 113	Immediate Action: All water fixtures used by residents will be tested immediately to identify current water temperatures. Any fixtures exceeding the maximum temperature of 116 degrees F will be adjusted to ensure compliance. Measures to Prevent the Problem from Occurring Again: The Facilities Director or Designee will implement a monthly schedule for all plumbing fixtures to ensure they are functioning properly and maintaining safe water temperatures. The Facilities Director will conduct a documented staff training on the importance of monitoring hot water temperatures and the procedures for reporting any discrepancies. Monitoring the Situation: The Facilities Director will be responsible for overseeing water temperature monitoring and ensuring adherence to the established protocols. The Facilities Director will conduct quarterly audits of all water fixtures to ensure compliance with temperature rules. Frequency of Monitoring: Monthly checks will be conducted on all water fixtures, with a report documented for each audit detailing compliance status and any corrective actions taken.	3/7/25 On-going On-going On-going	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE **General Manager**

(X6) DATE
3/10/25

STATE FORM

9R0211

Continuation sheet 1 of 20

Reviewed and acknowledged on 03/28/2025 by *Joyce Johnston*

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D 113	Continued From page 1 in room 411 was 118.2 degrees F. -The hot water temperature in the left master bathroom sink in room 508 was 118.0 degrees F. -The hot water temperature in the hallway bath in room 508 was 118.0 degrees F. -The hot water temperature in the left bathroom sink in room 515 was 118.6 degrees F. -The hot water temperature in the right bathroom sink in room 515 was 118.6 degrees F. Second observation of the water temperatures in the facility on 02/05/25 from 8:05am to 8:27am revealed: -The hot water temperature in the bathroom sink in room 403 was 117.3 degrees F. -The hot water temperature in the bathroom sink in room 411 was 117.7 degrees F. -The hot water temperature in the left master bathroom sink in room 508 was 117.1 degrees F. -The hot water temperature in the hallway bath in room 508 was 117.1 degrees F. -The hot water temperature in the left bathroom sink in room 515 was 120.2 degrees F. -The hot water temperature in the right bathroom sink in room 515 was 120 degrees F. Third observation of the water temperature in the left bathroom sink in room 515 from 10:51am to 10:55am revealed: -The faucet in the left bathroom sink ran from 10:52am to 10:54am, and when checking the hot water temperature, the surveyor's thermometer read 117.7 degrees F at 10:54am. -When checking the hot water temperature, the facility's thermometer read 117.1 degrees F at 10:54am. Interview with the resident in room 411 on 02/04/25 at 10:05am revealed: -She was independent with bathing.	D 113			

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D 113	Continued From page 2 -She had not noticed the water in the facility being too hot. -She was able to adjust the water temperature if she felt the water was too hot. -She had not been burned by the water in the facility. Interview with a medication aide (MA) on 02/05/25 at 8:16am revealed: -She assisted residents with bathing -There were several residents in the facility who required assistance with bathing. -She had not noticed the water in the facility being too hot. -She had not heard any residents complaining about the water temperatures being too hot. -When she assisted a resident with a shower, she let the water run while gathering the supplies for the shower, then tested the water with her hand or arm to make sure the water was not too hot or cold for the resident. -She checked with the resident to make sure the water was comfortable during their shower. Interview with a maintenance technician on 02/04/25 at 11:17am revealed: -He was one of three maintenance technicians at the facility. -The maintenance technicians were responsible for checking water temperatures every day. -The maintenance technicians usually checked one water temperature daily and recorded the temperature on a water temperature log. -The water temperatures should be between 112 degrees F and 116 degrees F. -He noticed the hot water temperatures in the facility seemed to vary throughout the day. -He had no hot water temperature readings greater than 116 degrees F. -A plumber was at the facility in the last couple of	D 113		

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D 113	Continued From page 3 weeks and adjusted the mixing valve on the water heater, but he was unsure of the date. -He notified the Facilities Management Director (FMD) if there were any issues with the facility's water temperatures. Review of the facility's December 2024 water temperature logs revealed: -There were 29 water temperatures recorded with no dates provided. -The water temperatures ranged from 103-115 degrees F. Review of the facility's January 2025 water temperatures logs revealed: -There was 1 water temperature recorded daily from 01/01/25 to 01/31/25. -The water temperatures ranged from 111-118 degrees F. Review of the facility's February 2025 water temperature logs revealed: -There was 1 water temperature recorded daily from 02/01/25 to 02/03/25. -The water temperatures ranged from 113-115 degrees F. Interview with the FMD on 02/04/25 at 11:55am revealed: -The maintenance technicians checked water temperatures in the facility daily and recorded the water temperatures on a temperature log. -A plumber was at the facility the previous week and performed preventative maintenance on the facility's boilers -The water temperature in residents' rooms should be 110-116 degrees F. -He had not received any reports from the maintenance technicians of water temperatures out of range.	D 113			

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D 113	Continued From page 4 -He would adjust the temperature on the water heaters today, 02/04/25. Second interview with the FMD on 02/05/25 at 10:54am revealed: -The temperatures on the water heaters were adjusted on 02/04/25. -He would adjust the temperatures on the water heaters again today, 02/05/25. Interview with the Administrator on 02/04/25 at 2:26pm revealed: -The maintenance technicians were responsible for checking water temperatures daily. -She was unsure of the water temperature range for residents' rooms. -She was unsure the last time a plumber was at the facility for water heater maintenance or issues. -When the maintenance technicians had water temperatures in residents' rooms that were too hot or cold, they should notify the FMD. -The FMD notified her of any maintenance issues or concerns that were considered significant repairs. -She had not received any reports of water temperatures exceeding 116 degrees F. -She was concerned about the water temperatures being elevated because a resident could be burned if the water was too hot. Second interview with the Administrator on 02/05/25 at 10:30am revealed: -The FMD and maintenance technicians adjusted the temperatures on the water heater on 02/04/25. -The maintenance technicians checked water temperatures on 02/04/25 and reported to her that the water temperatures were in range. -She would have the maintenance technicians	D 113	

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D 113	Continued From page 5 and FMD readjust the temperature on the water heaters today, 02/05/25.	D 113	10A NCAC 13F .0403 (a) Qualifications of Medication Staff Measures to Correct the Deficient Area of Practice:		
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure documentation for 1 of 3 sampled medication aides (Staff B) who administered medications to residents completed the state approved 5-hour and 10-hour or 15-hour medication aide training. The findings are: Review of Staff B's personnel record revealed: -Staff B was hired on 11/19/24 as a medication aide (MA). -There was no documentation Staff B completed the state approved 5 and 10 or 15-hour medication aide training. Review of the MA schedule provided on 02/04/25 revealed Staff B was scheduled as the MA for the 4th floor on the 7am-3pm shift on 02/04/25 and	D 125	Immediate Action: The Medication aides who did not complete the required training will be enrolled in the next available state-approved medication aide training program to ensure completion of the necessary 5-hour and 10-hour or 15-hour training. A documented review of training records for all current medication aides to ensure records for all current medication aides to ensure compliance with training requirements. Any discrepancies will be addressed immediately. Measures to Prevent the Problem from Occurring Again: The Administrator or designee will establish an internal protocol that requires all medication aides to complete state-approved training before administering medications. The Administrator will implement a training tracking system to monitor the completion of medication aide training and ensure timely renewals and updates. Monitoring the Situation: The Resident Care Managers will oversee the medication aide training program, ensuring all aides meet training requirements before administering medications. The Resident Care Managers will perform quarterly reviews of training records for medication aides to ensure compliance with training rules.	3/7/25	3/7/25 and on-going
					On-going

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D 125	Continued From page 6 02/05/25. Observation of the 4th floor medication pass on 02/04/25 between 8:54am-9:09am revealed Staff B administered medications to 2 residents. Interview with Staff B on 02/05/25 at 2:15pm revealed: -She had been passing medications at the facility. -She had not completed the state approved 5-hour and 10-hour or 15-hour medication aide training at this facility. -She completed the state approved medication aide training at her last job as an MA but left before she received a certificate. Interview with the Resident Care Coordinator (RCC) on 02/05/25 at 3:16pm revealed: -She did not know that a certificate was required for the state approved 5-hour and 10-hour or 15-hour medication aide training. -She did not know who was responsible for ensuring the MA had the state required certificate. Interview with the Administrator on 02/05/25 at 2:35pm revealed: -She had worked at the facility for 3 months. -She was not aware the state approved 5-hour and 10-hour, or 15-hour medication aide training was not completed for Staff B until 02/05/25. -She was not sure why the state approved 5-hour and 10-hour, or 15-hour medication aide training had not been completed. -The state approved 5-hour and 10-hour, or 15-hour medication aide training should have been completed before staff began working on the floor as a MA. -Human resources used a check list and verified that they had all the required documents for the staff to start working.	D 125	Frequency of Monitoring: The Resident Care Managers will conduct quarterly audits of medication aide training records, with reports submitted to the Administrator detailing compliance status and any necessary corrective actions.	On-going	

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D 125	Continued From page 7 -The RCC should have verified that all staff documents were completed. -She was responsible for ensuring all staff that needed the state approved 5-hour and 10-hour, or 15-hour medication aide training had one completed.	D 125	10A NCAC 13F .0504 (a & b) Competency Eval & Validation For LHPS Tasks Measures to Correct the Deficient Area of Practice: Immediate Action: The Administrator or Designee will conduct a competency evaluation for any licensed health professional who did not have the required evaluation and validation for support tasks. This evaluation will be carried out for a qualified supervisor or designated evaluator. The Administrator or Designee will assess the competency evaluation records for all licensed health professionals to identify any additional staff requiring evaluation and validation.	3/7/25
D 161	10A NCAC 13F .0504(a & b) Competency Eval & Validation For LHPS Tasks 10A NCAC 13F .0504 Competency Evaluation and Validation For Licensed Health Professional Support Tasks (a) When a resident requires one or more of the personal care tasks listed in Subparagraphs (a) (1) through (a)(28) of Rule .0903 of this Subchapter, the task may be delegated to non-licensed staff or licensed staff not practicing in their licensed capacity after a licensed health professional has validated the staff person is competent to perform the task. (b) The licensed health professional shall evaluate the staff person's knowledge, skills, and abilities that relate to the performance of each personal care task. The licensed health professional shall validate that the staff person has the knowledge, skills, and abilities and can demonstrate the performance of the task(s) prior to the task(s) being performed on a resident.	D 161	Measures to Prevent the Problem from Occurring Again: The Administrator or Designee will implement a standardized protocol for competency evaluations of all licensed health professionals performing support tasks. The Administrator or designee will establish a schedule for regular competency evaluations to be at least annually for all licensed health professionals to ensure ongoing compliance and skills validation. Monitoring the Situation: The Administrator or Designee will be responsible for monitoring compliance with the competency evaluation process and addressing any deficiencies.	On-going On-going
This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled staff (Staff B) had a licensed health professional evaluate				

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D 161	Continued From page 8 and validate for Licensed Health Professional Support tasks. The findings are: Review of Staff B's, medication aide (MA), personnel record revealed: -There was a hire date of 11/19/24. -There was no documentation that a licensed health professional performed a Licensed Health Professional Support tasks (LHPS) evaluation. Observation of the 4th floor medication pass on 02/04/25 between 8:54am-9:09am revealed Staff B performed a fingerslick blood sugar at 9:09am. Interview with the Resident Care Coordinator (RCC) on 02/05/25 at 3:15pm revealed: -She had not reviewed staff documents. -She thought that once the staff arrived on the floor all documents had been completed. -She did not know who was responsible for verifying that staff records were complete. Interview with the Administrator on 02/05/25 at 2:35pm revealed: -She had worked at the facility for 3 months. -She was not aware the LHPS was not completed for Staff B until 02/05/25. -She was not sure why the LHPS had not been completed. -The LHPS should have been completed before staff began working on the floor. -Human resources used a check list and verified that they had all the required documents for the staff to start working. -The RCC should have verified that all staff documents were completed. -She was responsible for ensuring all staff that needed an LHPS had one completed.	D 161	Frequency of Monitoring: The Administrator or Designee will conduct monthly audits of competency evaluation records for all licensed health professionals and detail compliance status and any corrective actions taken.		On-going

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D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunization 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 5 residents (#1) were tested upon admission for tuberculosis (TB) disease in compliance with the control measures by the Commission for Public Health. The findings are: Review of Resident #1's current FL2 dated 02/26/24 revealed diagnoses included type 2 diabetes mellitus, pulmonary hypertension, obstructive sleep apnea, hypercarbia, acute respiratory failure with hypercapnia, bipolar disorders, thrombocytopenia, and aortic valve stenosis. Review of Resident #1's Resident Register revealed: -Resident #1's admission date to the facility was 03/01/24.	D 234	10A NCAC 13F .0703 (a) Tuberculosis Test, Medical Exam & Immunizations Measures to Correct the Deficient Area of Practice: Immediate Action: The residents who did not receive TB testing upon admission will be tested. Documentation of this test will be added to the resident's medical file. The Administrator will conduct a review of the facility's admission procedures to identify gaps that led to the oversight and ensure all staff understands the requirements for TB testing. Measures to Prevent the Problem from Occurring Again: The Administrator will implement a standardized admission protocol, that includes a checklist ensuring TB testing is completed for all new residents prior to admission approval. The Administrator will provide a training session for all staff involved in the admissions process to reinforce the importance of TB testing and the updated procedures. Monitoring the Situation: The Administrator or Designee will conduct monthly audits of new admissions to ensure that all residents have completed TB testing as required.	3/7/25	3/7/25 and On-going
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D 234	Continued From page 10 -Resident #1 was admitted from home. Review of Resident #1's record revealed: -There was documentation of a tuberculosis (TB) test administered 12/30/23. -There was no documentation of the date the test was read, and the result documented was negative. -There was documentation of a TB test administered in Resident #1's right arm 02/24/24. -There was no documentation of the result of the TB test administered on 02/24/24. -There was documentation of a TB test administered in Resident #1's left arm on 02/27/24. -There was no documentation of the result of the TB test administered on 02/27/24. Interview with Resident #1 on 02/05/25 at 11:40am revealed -He was admitted to the facility a few months ago. -He was in the hospital before he came to the facility. -He had a TB test before, but he was unsure how many TB tests he had or when the TB tests were completed. Interview with the Resident Care Coordinator (RCC) on 02/05/25 at 1:20pm revealed: -Residents were required to have two TB tests before admission. -It was her responsibility to ensure residents had two TB tests. -She requested Resident #1's TB test records from a local hospital when he was admitted to the facility. -She thought the TB tests were read, but she was unsure where the documentation of the results was located.	D 234	Frequency of Monitoring: The Administrator of Designee will be responsible for monthly auditing of TB testing for new admissions, with corrective actions if any detailed in the audit.		On-going

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D 234	Continued From page 11 Interview with the Administrator on 02/05/25 at 2:16pm revealed: -Residents should have both TB tests prior to admission to the facility. -The RCC was responsible for ensuring the residents had two TB tests. -She was not aware the documentation for Resident #1's TB tests was not complete. -The TB test documentation should be complete with the date the TB test was administered, the date the TB test was read, and the result of the test. -It was important for residents to have complete documentation of their TB tests to ensure there was no evidence of TB.	D 234	10A NCAC 13F .0704 (b) Resident Contract, Information On Facility, And Resident Register Measures to Correct the Deficient Area of Practice: Immediate Action: The initial assessment for the resident who was not assessed within the required timeframe will be completed and signed immediately. Documentation will be updated to reflect this completion. The Administrator or Designee will conduct a review of all recent admissions to ensure that the initial assessments have been completed and signed within the required timeframe of all residents.		3/7/25
D 248	10A NCAC 13F .0704 (b) Resident Contract, Information On Facility & 10A NCAC 13F .0704 Resident Contract, Information On Facility, And Resident Register (b) The administrator or their management designee and the resident or the resident's representative shall complete and sign the Resident Register initial assessment within 72 hours of the resident's admission to the facility in accordance with G.S. 131D-2.15. The facility shall involve the resident in the completion of the Resident Register unless the resident is cognitively unable to participate. The Resident Register shall consist of the following: (1) resident's identification information including the resident's name, date of birth, sex, admission date, medical insurance, family and emergency contacts, advanced directives, and physician's name and address; (2) resident's current care needs including activities of daily living and services, use of assistive aids, orientation status;	D 248	Measures to Prevent the Problem from Occurring again: The Administrator or Designee will implement a protocol for conducting and documenting initial resident registers that includes specific timelines for completion (72 hrs of admission). Frequency of Monitoring: The Administrator or Designee will conduct weekly assessments to review registers are being completed timely.		3/7/25 & on-going 3/7/25 & on-going

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(A1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL-092-22	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/05/2025
NAME OF PROVIDER OR SUPPLIER THE EAST TOWER AT CARDINAL NORTH HILLS			STREET ADDRESS CITY STATE ZIP CODE 320 ST ALBANS DRIVE RALEIGH, NC 27609		
(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 248	Continued From page 12 (3) resident's preferences including personal habits, food preferences and allergies, community involvement, and activity interests; (4) resident's consent and request for assistance including the release of information, personal funds management, personal lockable space, discharge information, and assistance with personal mail; (5) name of the individual identified by the resident who is to receive a copy of the notice of discharge per G.S. 131D-4.8; and (6) resident's consent including a signature confirming the review and receipt of information contained in the form. The Resident Register is available on the internet website, https://info.ncdhhs.gov/dhsr/acts/pdf/resregister.pdf at no charge. The facility may use a resident information form other than the Resident Register as long as it contains the same information as the Resident Register. Information on the Resident Register shall be kept updated and maintained in the resident's record.	D 248			
	This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure a Resident Register was completed within 72 hours of admission to the facility for 2 of 5 sampled residents (#2 and #5). The findings are: 1. Review of Resident #2's current FL-2 dated 07/02/24 revealed diagnoses included atrial				

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NAME OF PROVIDER OR SUPPLIER THE EAST TOWER AT CARDINAL NORTH HILLS		STREET ADDRESS, CITY, STATE, ZIP CODE 320 ST ALBANS DRIVE RALEIGH, NC 27609			
(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 248	Continued From page 13 fibrillation, hyperlipidemia, heart failure, urine retention, prostatic hyperplasia, transient ischemic attacks, urinary tract infections, long term use of anticoagulants, falls, vitamin D deficiency, gastroesophageal reflux disease, lung cancer, hypertension, and small cell carcinoma of the neck. Review of Resident #2's Resident Register revealed: -He did not have an admission date. -His power of attorney signed his Resident Register on 06/27/23. Interview with the administrator on 02/05/25 at 2:35pm revealed she did not know that the Resident Register did not have an admission date. Refer to interview with the Administrator on 02/05/25 at 2:35pm. 2. Review of Resident #5's current FL-2 dated 07/31/24 revealed diagnoses included compression fracture of spine, elevated thyroid stimulating hormone, osteoporosis post-menopausal, localized rash, macular degeneration, hypertension, and trigeminal neuralgia. Review of Resident #5's Resident Register revealed: -She was admitted on 09/18/23. -She signed the Resident Register on 11/16/23. -Resident #2's Resident Register had not been signed by the Administrator or designee. Interview with the administrator on 02/05/25 at 2:35pm revealed she did not know that the Resident Register for Resident #5 had not been	D 248			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL-092-22	(X2) MULTIPLE CORRECTIONS: A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/05/2025
NAME OF PROVIDER OR SUPPLIER THE EAST TOWER AT CARDINAL NORTH HILLS		STREET ADDRESS, CITY, STATE, ZIP CODE 320 ST ALBANS DRIVE RALEIGH, NC 27609			
(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 248	Continued From page 14 signed. Refer to interview with the Administrator on 02/05/25 at 2:35pm. Interview with the Administrator on 02/05/25 at 2:35pm revealed: -The Resident Register was provided to the residents or their family by the Hospitality Service Manager for them to complete and then return. -The Hospitality Service Manager was responsible for ensuring that the Resident Register was complete and signed. -She was ultimately responsible for ensuring that all documents had been completed.	D 248	10A NCAC 13F. 1004(a) Medication Administration Measures to Correct the Deficient Area of Practice: Immediate Action: The Nurse Care Managers will review with each staff member responsible for the medication administration and reinforce the importance of following orders. Measures to Prevent the Problem from Occurring Again: The Nurse Care Managers will review the existing policies and procedures regarding medication administration to ensure all staff understand the protocols for verifying and following medication orders. The Nurse Care Managers will conduct a documented training for all staff involved in medication administration focusing on the importance of adhering to prescribing orders, proper documentation, and the consequences of non-compliance. Monitoring the Situation: The Nurse Care Managers will conduct monthly audits of medication administration records to ensure that all medications are administered according to orders and that documentation is complete.		3/7/25 3/7/25 & on-going
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: The facility failed to ensure that medications were administered as ordered for 1 of 5 sampled residents (#3) including a medication used to treat psychiatric conditions and a medication used to treat shortness of breath and wheezing. The findings are:	D 358			On-going

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL-092-22	(X2) MULTIPLE STRUCTURE A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/05/2025
NAME OF PROVIDER OR SUPPLIER THE EAST TOWER AT CARDINAL NORTH HILLS		STREET ADDRESS CITY STATE ZIP CODE 320 ST ALBANS DRIVE RALEIGH, NC 27609			
(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 358	Continued From page 15 Review of Resident #3's current FL2 dated 11/21/24 revealed diagnoses included dementia, coronary artery disease, gastroesophageal reflux disease, anxiety, low back pain, compression fracture, and repaired abdominal aortic aneurysm. a. Review of Resident #3's primary care provider's (PCP) after visit summary dated 11/21/24 revealed there was an order to start taking Seroquel 25mg 1 tablet at bedtime (Seroquel is a medication used to treat psychiatric conditions). Review of Resident #3's November 2024 electronic medication administration record (eMAR) revealed there was no entry for Seroquel 25mg 1 tablet at bedtime. Review of Resident #3's December 2024 eMAR revealed there was no entry for Seroquel 25mg 1 tablet at bedtime. Review of Resident #3's January 2025 eMAR revealed there was no entry for Seroquel 25mg 1 tablet at bedtime. Review of Resident #3's February 2025 eMAR revealed there was no entry for Seroquel 25mg 1 tablet at bedtime. Observation of Resident #3's medications on hand on 02/05/25 at 11:30am revealed Resident #3 had no Seroquel 25mg. b. Review of Resident #3's current FL2 dated 11/21/24 revealed there was an order for Albuterol Metered Dose Inhaler (MDI) 90mcg inhale 2 puffs every 6 hours as needed for shortness of breath and wheezing (Albuterol MDI	D 358			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL-092-22	(X2) MULTIPLE LOCATION STRUCTURE A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/05/2025
NAME OF PROVIDER OR SUPPLIER THE EAST TOWER AT CARDINAL NORTH HILLS		STREET ADDRESS, CITY, STATE, ZIP CODE 320 ST ALBANS DRIVE RALEIGH, NC 27609			
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D 358	Continued From page 16 is a medication used to treat shortness of breath and wheezing). Review of Resident #3's November 2024 electronic medication administration record (eMAR) revealed there was no entry for Albuterol MDI 90mcg inhale 2 puffs every 6 hours as needed for shortness of breath and wheezing. Review of Resident #3's December 2024 eMAR revealed there was no entry for Albuterol MDI 90mcg inhale 2 puffs every 6 hours as needed for shortness of breath and wheezing. Review of Resident #3's January 2025 eMAR revealed there was no entry for Albuterol MDI 90mcg inhale 2 puffs every 6 hours as needed for shortness of breath and wheezing. Review of Resident #3's February 2025 eMAR revealed there was no entry for Albuterol MDI 90mcg inhale 2 puffs every 6 hours as needed for shortness of breath and wheezing. Observation of Resident #3's medications on hand on 02/05/25 at 11:30am revealed Resident #3 had no Albuterol MDI 90mcg. Interview with a medication aide (MA) on 02/05/25 at 11:30am revealed: -He started working at the facility in January 2025. -When a resident received new medication orders, the order was faxed to the facility's pharmacy, filed in the resident's record, and a copy of the new order was left for the Resident Care Coordinator (RCC) to review. -The pharmacy entered the new medication order on the residents' electronic medication administration record (eMAR).	D 358			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL-092-22	(X2) MULTIPLE CORRECTIONS: A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/05/2025
NAME OF PROVIDER OR SUPPLIER THE EAST TOWER AT CARDINAL NORTH HILLS		STREET ADDRESS, CITY, STATE, ZIP CODE 320 ST ALBANS DRIVE RALEIGH, NC 27609			
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D 358	Continued From page 17 -If there were any issues with medications or the eMAR, he would report the issue to the RCC. -He was unsure about Resident #3's orders for Albuterol MDI and Seroquel 25mg from November 2024 because he just started working at the facility in January 2025. Interview with the RCC on 02/05/25 at 1:20pm revealed: -When a resident's family transported the resident to an appointment with the resident's primary care provider (PCP) or other provider, the family was supposed to return the paperwork to the facility staff. -Sometimes residents' family members did not return the paperwork from the PCP appointments to the facility staff. -The MAs or RCC were responsible for faxing residents' new medication orders to the pharmacy so the orders could be added to the residents' eMAR. -She was responsible for checking the residents' eMARs monthly for accuracy. -Resident #3's family transported Resident #3 to his PCP appointments. -She was unsure if Resident #3's family returned his paperwork after his PCP appointment on 11/21/24. -She thought Resident #3's order for Seroquel 25mg and Albuterol MDI 90mcg were discontinued because the medications were not covered by his insurance. -She thought Resident #3's family did not want him to take Seroquel 25mg and Albuterol MDI so Resident #3's PCP discontinued the medications. -She was unsure why Resident #3's orders for Seroquel 25mg and Albuterol MDI 90 mcg were not started or added to Resident #3's eMAR. -She sent residents' FL2s to the pharmacy on admission only, and did not send FL2s to the	D 358			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL-092-22	(X2) MULTIPLE LOCATION STRUCTURE: A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/05/2025
NAME OF PROVIDER OR SUPPLIER THE EAST TOWER AT CARDINAL NORTH HILLS		STREET ADDRESS CITY STATE ZIP CODE 320 ST ALBANS DRIVE RALEIGH, NC 27609	
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D 358	Continued From page 18 pharmacy when the FL2s were updated. -She sent the medication order sheets to the residents' PCPs for signature and then sent the signed copy to the pharmacy when received from the residents' PCPs. Interview with the Administrator on 02/05/25 at 2:16pm revealed: -When residents had an appointment with their PCP, any new orders were sent to the pharmacy by the MAs or RCC. -The pharmacy added new orders to the residents' eMARs. -The facility informed families that all paperwork from PCP visits should be given to facility staff. -The RCC checked residents' orders and eMARs daily. -All medication orders should be sent to the pharmacy so the pharmacy could add the orders to the eMAR for administration. -She was unsure why Resident #3's Seroquel 25mg and Albuterol MDI 90mcg were not added to the eMAR so Resident #3 could start taking the medications. -If the facility received an order for medications, the medication should be administered as the PCP ordered. -Residents' FL2s should be sent to the pharmacy at admission and when updated by the residents' PCP. Telephone interview with a Licensed Practical Nurse (LPN) at Resident #3's PCP office on 02/05/25 at 10:09am revealed: -Resident #3 was last seen by his PCP on 11/21/24. -The PCP added the order for Albuterol Metered Dose Inhaler (MDI) 90mcg inhale 2 puffs every 6 hours as needed for shortness of breath/whooping to the FL2 dated 11/21/24.	D 358	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL-092-22	(X2) MULTIPLE INSTITUTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/05/2025
NAME OF PROVIDER OR SUPPLIER THE EAST TOWER AT CARDINAL NORTH HILLS		STREET ADDRESS CITY, STATE, ZIP CODE 320 ST ALBANS DRIVE RALEIGH, NC 27609			
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D 358	Continued From page 19 -Resident #3's PCP ordered Seroquel 25mg 1 tablet at bedtime on 11/21/24. -Resident #3's insurance required a prior authorization for Seroquel 25mg, but the prior authorization was approved and Resident #3's insurance would pay for the medication. -Resident #3's PCP had not discontinued Seroquel 25mg or Albuterol MDI 90mcg, so both medications should be on his current eMAR. Telephone interview with a pharmacist at the facility's contracted pharmacy on 02/05/25 at 9:42am revealed: -The pharmacy did not have Resident #3's FL2 dated 11/21/24 with the Albuterol MDI 90mcg order. -The pharmacy did not have Resident #3's medication order for Seroquel 25mg dated 11/21/24. -All the residents' medication orders should be faxed to the pharmacy so the orders could be added to the residents' eMARs. -The facility should send all updated FL2 forms to the pharmacy when received. -If a resident did not take medications as ordered by their PCP, the condition for which the medication was prescribed could become worse. Based on observations, interviews, and record reviews, it was determined that Resident #3 was not interviewable. Attempted telephone interview with Resident #3's family member on 02/05/25 at 9:58am was unsuccessful. Attempted telephone interview with Resident #3's PCP on 02/05/25 at 10:04am was unsuccessful.	D 358			