STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 and the Harnett County Department of Social Services conducted an annual survey and complaint investigation on August 18, 2021 - August 20, 2021 and August 23, 2021. The complaint investigation was initiated by Harnett County Department of Social Services on August 13, 2021.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews the facility failed to ensure the facility was free of obstructions and hazards including a leaning, unsteady wooden fence and shrub growth in the walkways of the residents' courtyard, personal care hygiene products being stored unlocked in the common shower room on A and B hall and multiple residents' rooms shared and individual bathrooms; and multiple cleaning agents in janitor closets resulting in hazardous substances and chemicals being unattended and accessible to the 34 residents residing in the Special Care Unit (SCU) facility. The findings are:	D 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 079	Continued From page 1	D 079		

Observations of the Special Care Unit (SCU) courtyard on 08/18/21 at 9:00am and 10:51am revealed:
-The exit door leading to the SCU courtyard was unlocked.
-There was a wooden fence with plank boarding surrounding the courtyard.
-The back wall of the wooden fence was leaning inward slightly into the courtyard.
-The middle section of the back wall moved when pressure was applied to the section.
-There was missing and broken pieces of boarding at the base of the fence and scattered sections of boarding that were approximately one foot or smaller in size that were missing or loose.
-The shrubs and bushes had overgrown in the edges of the cement walkway of the courtyard that posed a fall or trip hazard.

Interview with the Regional Director (RD) on 08/18/21 at 11:00am revealed there were plans to have the fence replaced next week.

Observation of a shared bathroom in resident room B7 and B5 on 08/18/21 at 9:08am revealed:
-There was a 15-ounce (oz) plastic bottle of body wash on the sink.
-There was less than ¼ in the bottle.

Observation of resident room B7 on 08/18/21 at 9:08am revealed there was a white flat curtain rod with screws and 2 brackets on top of the dresser.

Observation of a soiled utility room located on the men's hall on 08/18/21 at 9:18am revealed:
-The soiled utility room was located at the end of the men's hallway.
-The door was in an open position.
-There were residents walking up and down the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 079	Continued From page 2	D 079		

hallway and resident rooms were in close proximity of the unlocked soiled utility room.
-There were scattered items including a bag and a wood square frame laying on the floor in the doorway of the room that posed a fall or trip hazard.
-There was an unsecured toilet that had been disconnected from the drain and water supply.
-There were three one-gallon bottles stored in a rack on the wall that included a liquid concentrated degreaser, a liquid concentrated odor neutralizer, and a liquid disinfectant.
-The three one-gallon containers had a screw top lid and hose connected to the system on the wall.
-The rack was located less than 2 ft from the floor.
-There was a warning label on the disinfectant that warned it might cause eye and skin irritation and to avoid breathing vapors or mist.
-There was a warning label on the odor neutralizer that warned contact with eyes caused a burning sensation and not for internal consumption.
-There was a warning label on the degreaser that warned it might cause eye and skin irritation and avoid breathing vapors or mist.

Observation of the laundry room on the men's hallway on 08/19/21 at 9:19am revealed:
-The door was unlocked.
-The laundry room was located at the end of the men's hallway and was not visible from the main hall.
-There were residents walking up and down the hallway and resident rooms were in close proximity of the unlocked laundry room.
-There was a one-gallon container of liquid bleach with approximately ½ remaining with labeled instructions of danger.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 079	Continued From page 3	D 079		

Review of a shift report document dated 07/15/21 from 6:00pm - 6:00am revealed a female resident was missing and found in the laundry room on the men's hall locked in asleep and not injured.

Interview with the Corporate Nurse on 08/23/21 at 12:11pm revealed:
-She got a call at 2:30am (could not recall the date) that the staff could not find a resident.
-Before she could get to the facility, she got a return call that the resident had been found.
-She was not made aware of how long the resident had been in the laundry room.
-There was a dispenser with chemicals in the laundry room.

Observation of the common bathroom on the women's hall on 08/18/21 at 9:20am revealed:
-There was a 15oz plastic bottle of body wash on the shower wall.
-The was a 13.5oz plastic bottle of shampoo on the shower wall.
-The warning label on the bottle of shampoo which warned to avoid contact with eyes.

Observation of a shared bathroom in resident room A8 on 08/18/21 at 9:30am revealed:
-There was a 11oz can of shaving cream on the sink.
-There was a label on the can of shaving cream that read contents under pressure do not put in hot water or near radiator, stoves or other sources of heat.
-There was an 8.75oz plastic bottle of scented liquid hand soap on the sink.
-There was 11oz can of shaving cream on the back of the toilet.
-There was a label on the can of shaving cream that read contents under pressure do not put in hot water or near radiator, stoves or other

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 079	Continued From page 4 sources of heat. Observation of a janitor closet on the women's hall on 08/18/21 at 9:39am revealed: -The door was open, and a resident was walking past to the laundry room. -There was a cleaning system present in the room. -There was a gallon of disinfectant with a screw top lid and hose connected to the system on the wall. -The label warned it may cause eye and skin irritation and avoid breathing vapors or mist. -There was a gallon of odor neutralizer with a screw top lid and hose connected to the system on the wall. -The label warned contact with eyes causes a burning sensation. Not for internal consumption. -There was a gallon of super cleaner/degreaser with a screw top lid and hose connected to the system on the wall. -The label warned it may cause eye and skin irritation and avoid breathing vapors or mist. -There was a gallon of mop cleaner with a screw top lid and hose connected to the system. -The label warned it may cause eye and skin irritation and may be harmful if swallowed or inhaled. -There was an open gallon of bleach sitting on the floor. -The label warned it may cause eye and skin irritation and may be harmful if swallowed or inhaled. Observation of a resident room A12 on 08/18/21 at 9:55am revealed: -There was an 8.75oz plastic bottle of lotion on the bedside table. -There was an 8oz plastic bottle of lotion on the bedside table.	D 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 079	Continued From page 5 -There was a ceramic cup with nail clippers and tweezers on the bedside table. Observation of a common bath on the right side of the men's hallway on 08/18/21 at 10:05am revealed: -The entrance door to the common bath was unlocked. -There were residents' rooms on both side of the common bath. -There was an 18-ounce bottle of moisturizing body wash with approximately 1/4th of the body wash remaining, stored on the sink beside the water fixture. Observation of an unlocked storage box located on the right wall of the common bath on the right side of the men's hallway on 08/18/21 at 10:07am revealed: -There was an unlocked storage box located on the right wall containing a 1.5 ounce can of shaving cream with a warning that contents were under pressure. -There were 4 disposable razors with a removable cap over the blades. -There was one 13-ounce jar of petroleum jelly with a small amount remaining that was adhered to the bottom and sides of the jar. -There was a 11.5 ounce of a food grade lubricating silicone with labeled instructions of danger, extremely flammable, contained gas under pressure, caused skin and serious eye irritation, might cause drowsiness or dizziness and might be fatal if swallowed and entered into the airways. -There was a small bottle of shaving cream stored in the box without a cap with approximately ½ of the shaving cream remaining. -There was a 5.2-ounce container of a deodorant solid with approximately ½ remaining with labeled	D 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 079	Continued From page 6	D 079		

directions for external use only and a warning label to get medical attention or contact Poison Control Center if swallowed.

Observation of a shared bathroom for resident room #A7 and #A5 on the men's hall on 08/18/21 at 10:20am revealed there was an opened bottle of body wash with approximately ½ of the liquid body wash remaining stored on the sink beside the water fixture.

Interview with a personal care aide (PCA) on 08/18/21 at 8:55am revealed personal care items were kept in the residents' rooms.

Interview with another PCA on 08/18/21 at 9:00am revealed personal care items were kept in the residents' rooms.

Telephone interview with the Transporter/PCA on 08/21/21 at 5:23pm revealed there were at least 3 named residents that wandered in and out of the rooms at the facilty.

Interview with the Resident Care Coordinator (RCC) on 08/18/21 at 10:36am revealed:
-Staff were responsible for ensuring all toiletry items were secured and stored on the top shelf in each residents' room closets.
-The residents toiletry items were not secured with a lock in the residents' closets.
-She thought there would be a safety risk that residents could be harmed from toiletry items being left out and in the residents reach in common rooms and shared bathrooms because the residents could accidentally ingest one of the toiletry items or accidentally get the product in their eyes.
-The razors should have never been left unsupervised and accesible to residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 079	Continued From page 7	D 079		

-A resident could have been cut and injured badly by the razors being left and accessible to residents.
-Staff were responsible to ensure nothing was left out that could have harmed the residents.
-The storage box located on the wall of the common bath on the right side of the men's hallway should have remained locked at all times.

Interview with the Assistant RCC on 08/23/21 at 9:32am revealed:
-Personal care items should have been kept locked up.
-Razors were to be kept locked up in the medication room.
-Lotion and shaving cream had always been kept in the resident's rooms.
-She did not know of any incidents were the residents had ingested any person care products.

Interview with the Corporate Nurse on 08/23/21 at 12:11pm revealed:
-A female resident was found locked in the men's hall laundry room (date unknown).
-There was a dispenser with chemicals in the laundry room.
-The female resident would not have been safe around chemicals.
-She would not be able to say for sure that the female resident would not drink something she should not, and it could harm her.

Interview with the Administrator on 08/23/21 at 3:36pm revealed:
-All chemicals should always be locked.
-Personal care items should be kept locked when not in use.
-The metal toolbox was put in the common bathrooms to keep personal care items locked up.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 079	Continued From page 8 -His expectation was for them to be kept locked up. -His concerns would be a resident could drink something they should not or get something in their eyes. -He had not noticed anything being left out when he made rounds (walked though) in the facility. -He came to the facility at least three times a week. -He might not stay all day but he would walk around and looked when he came to the facility. Interview with the Regional Director on 08/23/21 at 4:00pm revealed he expected all chemicals to be kept locked. _____ The facility's failure to secure hazardous substances including multiple hazardous cleaning products such as bleach, concentrated degreasers and disinfectants were left unsecured in a population where residents had dementia and cognitive deficits. The staff identified at least 2 residents who were known to have wandering behaviors with documentation of one incident for one of the residents known to wander being found by staff locked inside the laundry room. This failure was detrimental to the health, safety, and welfare of the residents in the SCU and constitutes a Type B Violation. _____ The facility provided a plan of protection (POP) in accordance with G.S. 131D-34 for this violation on 08/18/21. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 07, 2021	D 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 270	Continued From page 9	D 270		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews and record reviews, the facility failed to provide supervision according to needs of 1 of 6 sampled residents residing in a Special Care Unit (SCU) for a resident who had a history of wandering, elopement and exit seeking behaviors who eloped from the facility (#4). The findings are: Review of the facility's current license effective 01/01/21 revealed the facility was a Special Care Unit (SCU) with a licensed capacity of 36 residents. Review of the facility's undated Supervision Policy revealed: -Residents would be monitored visually in the common area when there was one or more resident up and about in that area. -This would provide supervision for those residents not being assisted with their activities of daily living. -Staff would rotate monitoring the common areas where residents were gathered for activities or leisure time.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 270	Continued From page 10	D 270		

-One staff member would be present in the common area while other staff were caring for the residents' needs.
-The management staff was included in the rotation to assist the direct care staff during the regular business hours.

Review of the facility's undated Elopement policy revealed:
-The facility would maintain a safe environment for the residents.
-Staff would visually monitor the residents at a minimum of every 2 hours.
-More frequent checks would be scheduled if a resident was exhibiting signs of exit seeking, up to one-on-one supervision if necessary.
-There were documented instructions regarding what to do when a resident was missing.

Review of the facility's Disclosure Statement revealed:
-The purpose of the facility was to provide a safe, secure, familiar and consistent environment for the cognitively impaired resident that promoted mobility while using the least restrictive measures to prompted independence.
-It included a security system that prevented inappropriate or unsupervised movement into or out of the unit.
-The facility provided 24-hour supervision by appropriate trained staff.

Review of Resident #4's current FL-2 dated 04/26/21 revealed:
-Diagnoses included dementia, hypertension, schizophrenia with delusions/paranoia, left kidney lesions, vitamin B12 deficiency, history of cerebrovascular accident and diastolic dysfunction.
-The resident was constantly disoriented and had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 270	Continued From page 11	D 270		

wandering behaviors.
-The resident was ambulatory.
-The resident was admitted to the SCU on 04/26/21.

Review of Resident #4's current assessment and care plan dated 04/27/21 revealed:
-The resident had wandering behaviors.
-The resident had "no problems" with ambulation and used no assistive devices.
-The resident was sometimes disoriented and had significant memory loss, requiring direction.

Review of Resident #4's Admission Criteria Review dated 04/25/21 revealed the resident habitually wandered or would wander out of the facility and would not be able to find the way back.

Review of Resident #4's SCU profile dated 07/07/21 revealed:
-The resident's short term and long-term memory were impaired.
-The resident's memory recall was documented as "none".
-The resident's cognitive impairments were documented as moderately independent - having some difficulty in new situations, moderately impaired - having poor decision making, supervision required and severe impairment - unable to make decisions.
-The resident's special management needs included staff to manage the resident's behavior daily and consistently required staff intervention for reminders.

Review of Resident #4's monthly profile summary dated 08/09/21 revealed:
-The resident was independent with ambulation.
-The resident was friendly, quiet and anxious.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 270	Continued From page 12 -There was no documentation addressing increased supervision for wandering and exit seeking behaviors. Review of the facility's shift report notes revealed: -On 04/29/21 on the 7:00pm to 7:00am shift, Resident #4 had walked the halls since 11:30pm and would not stay in his room "for nothing", roaming all night long until "daybreak". -On 05/03/21 on the 7:00pm to 7:00am shift, Resident #4 was up most of the night and kept going into other residents' rooms; "we kept redirecting him". -On 05/06/21 on the 7:00pm to 7:00am shift, Resident #4 had been redirected to his room multiple times and was going into other residents' rooms. -On 05/14/21 on the 7:00pm to 7:00am shift at 10:45pm, Resident #4 started his "rampage" going in and out of other's rooms and kept coming out of his room. At 11:30pm, Resident #4 kept banging on the doors to an office "talking about he's leaving or something". -On 05/17/21 on the 7:00pm to 7:00am shift at 3:00am, Resident #4 roamed. -On 06/06/21 on the 7:00pm to 7:00am shift at 8:30am, Resident #4 went into a female resident's room and started eating the resident's food. -On 06/15/21 on the 7:00pm to 7:00am shift, Resident #4 kept using the bathroom on the floors in the bedroom as well as on the hallway floor, he was pulling off his adult briefs and making a mess with them; he also kept trying to go into other's rooms; Resident #4 needed something that could restrain him through the days and nights, "he's really too much". -On 06/19/21 on the 7:00pm to 7:00am shift at 12:30am, Resident #4 started traveling the halls and into other's rooms bothering them and used	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 270	Continued From page 13	D 270		

the bathroom on hallway floors and bedroom floors, "this isn't the place for him to be, seriously".
-On 06/22/21 on third shift, Resident #4 had been roaming the halls about all night long giving staff a hard time. The resident finally went to sleep about 3:00am this morning.
-On 07/18/21 on the 6:00pm to 6:00am shift, a female resident wanted to call the police on Resident #4.

Review of Resident #4's mental health provider note dated 07/27/21 revealed the resident was calm and no agitation or behavioral issues but was often seen walking and wandering around the facility.

Confidential interview with a staff revealed:
-Resident #4 went in everyone's room.
-Resident #4 wandered in and out of rooms picking up clothes and shoes.
-Resident #4 would have on 5 pair of pants and 3 shirts from going in everyone's room.
-She never observed Resident #4 in anyone's bed.
-Staff were not told to increase supervision for Resident #4 but she checked on him every few minutes.

Interview with a resident on 08/18/21 at 9:30am revealed:
-Resident #4 came in her room three or four times a day and at night.
-Resident #4 would lay in her bed.
-She was afraid of Resident #4.

Interview with a second resident on 8/18/21 at 9:32am revealed:
-Resident #4 went in everyone's room.
-Resident #4 scared the female residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 270	Continued From page 14	D 270		

-Resident #4 would lay in everyone's bed and "they [management] did not do much about it."
-Resident #4 went through "people's stuff."

Interview with a personal care aide (PCA) on 08/19/21 at 11:00am revealed Resident #4 "rambled" in other residents' rooms, in the hallways and pushed on all the exit doors of the facility.

Telephone interview with a medication aide (MA) on 08/19/21 at 5:25pm revealed:
-Resident #4 was a "roamer", meaning the resident wandered.
-Resident #4 liked to wander into other residents' rooms and tried to get out of the facility.

Telephone interview with the Transporter/PCA on 08/21/21 at 5:23pm revealed Resident #4 was a resident that staff had to keep an eye on because he was into something, always touching something and in other residents' rooms requiring redirection.

Interview with the Resident Care Coordinator (RCC) on 08/18/21 at 11:58am revealed:
-Resident #4 went everywhere, in other residents' rooms; he was a wanderer.
-One of the female residents had complained Resident #4 went into her room in the afternoons and at night and picked up her personal items.
-There were no other residents that complained about Resident #4 wandering into their room that she was aware of.
-Staff were responsible to redirect Resident #4 when he went into other residents' rooms.
-Resident #4 was not placed on any increased supervision.

Confidential interview with a second staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 270	Continued From page 15	D 270		

revealed:
-Resident #4 wandered all over the facility and liked to stand at the exit doors.
-Resident #4 was "everywhere" and needed staff to keep a close watch on him to redirect him because he wandered, however, staff were not able to keep up with him and care for the other residents at the same time.
-Resident #4 was not on any increased supervision.

Review of Resident #4's mental health provider note dated 05/04/21 revealed the resident had tried to get out of the fence in the yard when outside.

Interview with a second PCA on 08/19/21 at 11:00am revealed:
-Resident #4 was "smart like Houdini".
-There was an incident approximately one month ago when Resident #4 attempted to jump across the fence in the courtyard of the facility however staff saw the resident before he jumped over and got the resident down off the fence in the SCU courtyard.
-She reported the incident to a MA.
-The MA no longer worked at the facility.
-The MA did not provide any guidance on how to supervise Resident #4 other than to "just check on him".
-Resident #4 was not placed on any additional supervision after the incident.
-She decided to start checking on Resident #4 at least every 30 minutes but was not instructed to do so.
-She did not document when she checked on Resident #4 every 30 minutes.

Telephone interview with the Transporter/PCA on 08/21/21 at 5:23pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 270	Continued From page 16 -Usually, Resident #4 stood at the door and watched people go into the facility and the resident would attempt to run up to the exit door. -Resident #4 attempted to slip out behind staff when the exit doors opened and had to be redirected. -She had previously observed Resident #4 attempt to climb the fence in the SCU courtyard by placing a chair at the fence and attempt to climb over. -She had observed Resident #4 attempting to climb the fence in the courtyard "a couple of times" and would redirect the resident back inside. -There had been times Resident #4 was observed outside by himself trying to get out of the fence in the SCU courtyard. -The SCU courtyard exit door was not locked. -Resident #4 would attempt to climb the fence in the courtyard when there was no staff outside with him and when staff were outside with him. -She informed the RCC when she saw Resident #4 attempting to get out of the facility by going over the fence in the SCU courtyard. -Staff were not instructed on any type of supervision for Resident #4 when he attempted to exit the facility other than to remove the chairs from the SCU courtyard and redirect the resident. -Resident #4 was a very strong man (physically) and had attempted to get out so much that he "stayed at the fence trying to get out" and would drag chairs back out of the facility and into the SCU courtyard. -She was informed by other staff Resident #4 had made a "hole" in the fence in the SCU courtyard (no date provided). -Resident #4 constantly tried to get out of the facility, he was an exit seeker. -During her shifts, all residents in the SCU were accounted for by the Assistant RCC who worked	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 270	Continued From page 17	D 270		

as a MA; she was not sure about the other MAs because she only worked when the Assistant RCC was working as a MA.
-The PCAs were also responsible to ensure where their assigned residents were.
-Most of the time, staff checked on residents every 30 minutes.
-She did not document when she checked on residents.

Interview with the RCC on 08/18/21 at 11:58am revealed:
-Resident #4 had never gotten out of the facility before.
-Resident #4 would walk constantly and went to the exit doors of the facility.
-Resident #4 would knock and pushed the bars on the exit doors.
-Resident #4 was not placed on any increased supervision.
-No resident was on increased checks.

Telephone interview with the Regional Director (RD) on 08/18/21 at 6:28pm revealed:
-The door to the SCU courtyard was never locked.
-Staff were responsible to monitor the area when residents went outside in the courtyard.
-It was possible for residents to go out in the courtyard without staff.

Interview with the RCC on 08/23/21 at 2:40pm revealed:
-She was aware Resident #4 had shaken the fence out in the courtyard.
-In June 2021 Resident #4 was seen standing on a chair at the fence.
-She did not remember who, but someone came and got her, and she had all the chairs brought inside.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 270	Continued From page 18 Interview with a neighbor in the surrounding community on 08/23/21 at 8:12am revealed: -There was an incident approximately a few months ago when the neighbor in the surrounding community had observed Resident #4 on the outside of the facility without staff. -The neighbor could not remember the exact day but knew the incident occurred on a weekday in the afternoon and the weather was sunny and warm that day. -The neighbor noticed Resident #4 walking toward the highway in front of the facility on the left side of a church located next to the facility (on the opposite side of the church next to the facility). -Resident #4 proceeded to walk beside the road in front of the facility and passed the front of the facility. -The neighbor did not realize it was a resident at the facility at that time and thought it was someone who was intoxicated by the way the resident was walking. -The neighbor watched the resident because he was walking too close to the busy road. -Resident #4 turned in his direction of walking at the side road next to the facility and almost fell when he started turning. -The neighbor contacted the facility and asked staff if they were missing any residents. -Two staff members came to the road where Resident #4 was walking and picked the resident up on a van. -The neighbor knew it was Resident #4 that was observed walking down the road that day because the resident was recognized as the same resident seen on television on 08/12/21 when a silver alert was issued. Interview with a PCA on 08/18/21 at 3:53pm	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 270	Continued From page 19	D 270		

revealed:
-She was working a couple of months ago when Resident #4 climbed over the fence.
-Resident #4 put a chair up to the fence and climbed over.
-Resident #4 was seen on the outside at the women's hall end door.
-She was not sure who assisted Resident #4 back into the building.
-Residents were to be checked on every two hours.
-PCAs were assigned residents but most of the time the PCAs worked together on their halls checking on the residents.

Telephone interview with a MA on 08/19/21 at 5:25pm revealed:
-Resident #4 had broken the SCU's courtyard fence twice.
-The first time occurred shortly after Resident #4 was admitted to the facility when the resident placed a chair at the SCU courtyard at the fence and climbed over the fence which caused the fence to break.
-She was aware of an incident when Resident #4 kept pulling on the fence to get out of the facility but at that time the chairs in the SCU courtyard had been removed to prevent the resident from climbing over.
-Staff redirected Resident #4 when he pulled on the fence in the SCU courtyard.

Interview with a housekeeper on 08/19/21 at 9:15am revealed:
-He was not working when Resident #4 eloped from the facility on 08/12/21.
-He was working the first time Resident #4 got out of the facility without staff.
-The incident occurred approximately June or July 2021.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 270	Continued From page 20	D 270		

-Resident #4 got a chair and climbed out in left corner of the fence in the SCU courtyard of the facility.
-Staff found Resident #4 wandering outside on the grounds of the facility the same day he climbed over the fence.
-The RCC was aware of the incident in June/July 2021, he thought all staff knew he got out on that day.
-Resident #4 always stood at the exit doors.
-Staff called Resident #4 "Houdini" because he had gotten out of the facility.

Confidential interview with a third staff revealed:
-She was aware Resident #4 had gotten out of the facility before 08/12/21.
-Resident #4 climbed over the fence by putting a chair up to the fence.
-PCAs were assigned residents and that person was responsible for checking on their residents every 2 hours.
-Most of the staff worked together to get the job completed.

Confidential interviews with a fourth staff revealed:
-Resident #4 got out the facility the first time and was seen by someone outside of the facility (no date provided).
-The facility was notified that a resident was outside on the highway.
-A staff went out and brought Resident #4 back into the facility.
-Resident #4 got out a second time by climbing over the fence by putting a chair up to the fence (no date provided).
-Resident #4 was a tall person.
-Resident #4 was seen by staff and someone went out and brought him back into the facility.
-There were no interventions put into place

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 270	Continued From page 21	D 270		

except to keep him in the dining room while they were feeding residents.

Interview with the RCC on 08/19/21 at 3:47pm revealed:
-She was aware Resident #4 attempted to exit the facility one time shortly after the resident's admission to the facility however staff had never notified her the resident had previously exited out of the facility.
-Resident #4 was never placed on any increased supervision, however increased supervision for the resident would have helped staff stay more aware of where Resident #4 was always.
-She had concerns they (facility staff) did not protect Resident #4 as they should have knowing that he was at risk for exit seeking and wandering.
-There should have been more "hands on" supervision with Resident #4, one on one supervision or at least attempts to find a different facility for to meet the resident's needs.

Interview with the Assistant RCC on 08/23/21 at 9:32am revealed:
-She was made aware on 07/17/21 at 7:23pm that Resident #4 had knocked a portion of the outside fence down.
-Maintenance was called and the fence was put back up that evening.
-She was not aware of any other time Resident #4 had gotten out the facility.

Interview with the Corporate Nurse on 08/23/21 at 12:11pm revealed:
-She was never made aware that Resident #4 had gotten out of the facility.
-She was aware he tried to climb over the fence with a chair.
-She would expect it to be reported immediately.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 270	Continued From page 22	D 270		

-There was no increased supervision for residents that wandered.
-The wanderers were to be checked every 30 minutes.
-Resident #4 was not placed on any increased supervision.

Interview with the Administrator on 08/23/21 at 3:36pm revealed:
-He had worked in the facility as a MA on the weekend and sometimes during the week when he was needed.
-Resident #4 but could be redirected.
-He saw him standing looking at the fence.
-His concerns would be that Resident #4 would need to be redirected if when anyone saw him at the fence.
-He was aware Resident #4 had gotten out one time before by jumping over the fence.
-A staff member went out and got him.
-He would expect to be notified if Resident #4 was getting out or trying to get out of the facility.

Interview with the Regional Director (RD) on 08/23/21 at 4:00pm revealed:
-His expectation was for the MA to report any elopement to the RCC and then report it to him.
-He was not aware Resident #4 had eloped prior to 08/12/21.
-He had to find out where the staffs' communication break down occurred with Resident #4's exit seeking behaviors and elopements to ensure the residents' safety.
-There was an incident when the RCC notified him that Resident #4 had tried to get out and wanted to take the chairs out of the courtyard.
-The Assistant RCC sent him a picture of the broken courtyard gate and he called her and asked how Resident #4 broke the gate (no date provided).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 270	Continued From page 23	D 270		

-Staff would go out and get him when Resident #4 went into the courtyard.
-He would have put him 1 on 1 if he had known about him getting out.
-The facility may not have been able to meet Resident #4's needs.
-He would never take the risk of a resident getting hurt.
-His concern was that staff had not notified him concerning Resident #4's previous elopements.
-He was not aware of Resident #4's history of elopements prior to the resident's admission to the facility.

Review of an incident report for Resident #4 from the county's Sheriff Department dated 08/12/21 revealed:
-On 08/12/21 at 11:22am, a Sheriff's Deputy responded to the facility due to a missing person.
-Observations of the weather was clear, daylight with a temperature of 95 degrees Fahrenheit (F).
-Upon arrival, staff reported Resident #4 had walked away from the facility around 11:00am during a fire alarm.
-It was determined Resident #4 was in the building at 11:00am by reviewing the surveillance cameras.
-During the review of the surveillance cameras, the Deputy was unable to view the recorded surveillance at the facility's exit door cameras.
-The Deputy was advised Resident #4 liked standing at the door, waiting for staff to open the doors so he could get out of the building.
-Two deputies searched the facility to ensure the resident was not hiding in the building.
-K-9 units responded to the location and Emergency Medical Services (EMS) responded to help with the incident.

Review of a local EMS dispatch record form for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 270	Continued From page 24 Resident #4 dated 08/13/21 revealed: -In the history and present illness there was an entry the resident had been missing for 20 hours; the heat and humidity had been high with weather advisories. -The resident had been found approximately 150 yards in a field/wooded area (off the same named road where the facility was located). -A team of responders located the resident lying down and the resident was covered in fire ants, bees, leaves and debris. -The resident was removed from the wooded area location and transported by an all-terrain vehicle (ATV) to the awaiting EMS unit. -The chief complaints were documented as decreased level of consciousness, dehydration/hypovolemia and insect stings with a duration of 20 hours. -The resident's body was rinsed off and the ants removed. -The resident's eyes were also flushed to help remove the ants. -The resident had altered level of consciousness, unresponsive behavioral/psychiatric disorder, stings and venomous bites. -The resident's initial acuity was critical. -Cooling measures were started as decontamination was undertaken. -At 9:10am, the resident was loaded and was unresponsive. -At 9:11am, the EMS staff were unable to feel or hear the resident's blood pressure, no pulses felt in the resident's wrists, his carotid pulse (the neck arteries found on the side of the neck) was weak and the pulse oximetry (an external device used to measure the oxygen concentration in the blood) would "not pick up" (show a reading). -At 9:12am, the resident's respiratory efforts were documented as labored. -At 9:20am, a 12 lead EKG performed, and a	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 270	Continued From page 25 STEMI (a severe type of a heart attack (MI) was considered, however due to the resident's condition, it was decided to transport to the closest emergency room (ER). -The resident's temperature was 99 degrees F rectally. -At 9:21am, the local ER was contacted by radio and the ER trauma room was requested. -At 9:29am, the resident arrived at the local ER for treatment. Review of Resident #4's history and physical from the local hospital with an arrival date of 08/13/21 revealed: -The resident had a past medical history of severe cognitive impairment, dementia and schizophrenia who was brought in by EMS after being found in the woods. -The resident had apparently left the facility on 08/12/21 around 10:30am and had been missing for the last 24 hours and was found per EMS covered in fire ants and yellow jackets. -On arrival to the ER, the resident was still covered in fire ants, swelling/redness to bilateral eyes and the resident was able to groan to painful stimuli but was not verbally responsive and had some spontaneous eye opening. -The resident was admitted to the medical team for further management of septic shock due to pneumonia, rhabdomyolysis and acute MI. (Rhabdomyolysis is a life-threatening syndrome caused by direct or indirect muscle injury). -The resident was covered in red hives head to toe likely secondary due to fire ant/yellow jacket bites. -The resident had acute hypoxic respiratory failure and was intubated on 08/15/21 for airway protection, mixed shock with multiorgan failure. -The resident was critically ill and needed emergent dialysis with continued attempts to	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 270	Continued From page 26 transfer tertiary care facility for dialysis. Observations of the location from the highway where Resident #4 was found revealed the resident was found approximately 0.3 miles (distance from the highway) in a wooded area on the opposite side of the road where the facility was located. Interview with the Resident Care Coordinator (RCC) on 8/13/21 at 1:52pm revealed: -She was present when Resident #4 left the facility unsupervised. -She was in her office with the Corporate Nurse. -The fire alarm went off and the RD responded to see why the alarm went off. -She and the Corporate Nurse were talking with a resident in a wheelchair, so it took a minute for her to get out of her office. -She silenced the alarm at the nurses' station by entering the code. -The RD said he knew where the smoke that set the alarm off was coming from which was the grill. -The RD called the alarm company to ensure they were aware of the false alarm and that the fire department did not need to respond. -She told staff to "make sure the doors were secure" while standing at the nurses' station. -The housekeeper was on the men's hall and a personal care aide (PCA) was standing near her office in the hallway. -The fire doors closed on the women's hall and the PCA had to go on the other side of the women's hall to secure the doors. -The fire alarm panel reset, and she heard the doors lock. -Staff checked to ensure the doors were locked. -The RD told staff to start a head count. -The Assistant RCC came to her office and	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 270	Continued From page 27	D 270		

notified her she could not find Resident #4.
-Staff had already searched the building.
-Staff searched inside and outside of the building.
-She called 911 at 11:32am.
-Law enforcement came to the facility and a missing person's report was completed for Resident #4
-A silver alert was issued for Resident #4.
-The smoke that set the fire alarm off came from the grill outside.
-Resident #4's family member called to let her know Resident #4 was found (8/13/21).
-Resident #4 was still hospitalized.
-Resident #4 was receiving fluids for dehydration.
-Resident #4 had never eloped before.
-Resident #4 was very smart and liked to be at the door.
-Resident #4 would try to do whatever he could and watched what we do.
-Resident #4 knew "we mash it [keypad at the doors] and he will mash it as well."
-Resident #4 did not push on doors constantly.
-Resident #4 could converse, he knew his address, and his family member.
-Resident #4 had been a resident since April 2021 and did not bother anyone.
-Resident #4 "stayed to himself."

Interview with the RCC on 08/19/21 at 2:54pm revealed the last time Resident #4 was seen by staff was around 10:00am on 08/12/21.

Observation of the surveillance camera with the RCC on 08/19/17 at 2:54pm revealed Resident #4 was last seen on the surveillance camera walking toward the women's hall at approximately 8:30am.

Interview with the Assistant Resident Care Coordinator (RCC) on 08/23/21 at 9:32am

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 270	Continued From page 28	D 270		

revealed:
-The morning of 08/12/21 the last time she remembered seeing Resident #4 was at 7:30am when he was eating breakfast.
-When the fire alarm went off, she came out of her office and went to do a head count of all the residents (estimated time between 10:35am -10:45am).
-She counted 34 residents and there should have been 35 so, she counted a 2nd time just to make sure.
-She realized Resident #4 was missing.
-She notified all staff and management and they started looking under beds, in closets and behind doors looking for him.
-Other staff searched outside around the building, around the church that is next door, around the trash bin and down the dirt road that was behind the facility.
-The RCC, RD and a MA got in their cars and began searching for Resident #4 up and down the road.
-Resident #4 would always be in sight in the mornings, He was constantly walking until around 2:00pm. After 2:00pm medications he would begin to sit some.

Telephone interview with a MA on 08/19/21 at 5:25pm revealed
-On 08/12/21(the day Resident #4 eloped), just before 10:00am, Resident #4 was outside in the courtyard and was pulling on the middle section of the back fence in the SCU courtyard.
-One of the residents alerted her that Resident #4 was outside pulling on the fence in the SCU courtyard.
-She went outside to the SCU courtyard and brought Resident #4 back into the facility and into the common living room (located beside the exit door to the SCU courtyard).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 270	Continued From page 29	D 270		

-This was the last time she saw Resident #4 on 08/12/21.
-The middle section of the back fence in the courtyard was leaning to the point the fence was movable from Resident #4 pulling on the fence, "it needs to be replaced".
-Resident #4 was always seen by staff day and night, walking around the facility.
-There was no plan in place for increased supervision for Resident #4 that she was aware of.

Observation of the SCU's courtyard exit door on 08/19/21 at 7:48am revealed:
-The exit door was not locked.
-The RCC was prompted regarding the unlocked exit door.
-The RCC locked the exit door for the SCU courtyard.

Interview with a maintenance staff on 08/23/21 at 8:50am revealed:
-The middle back section of the SCU courtyard fence was braced with a board on 08/12/21.
-He was not aware of any incident that caused the fence to break, the fence was "just old, a little weak and needed replacing.
-He was not aware of Resident #4 getting out or attempting to get out of the fence in the SCU courtyard.
-The road in front of the facility was a very busy highway and he would have concerns that a resident might get hurt because of the heavy traffic if a resident was unsupervised outside of the facility.

Telephone interview with Resident #4's family member on 08/21/21 at 10:48 am and 3:30pm revealed:
-The resident had dementia but was "fine" prior to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 270	Continued From page 30	D 270		

08/12/21, the resident did not have any physical limitations and had no difficulty walking.
-The family member was told by the RCC the resident had a history of watching the exit doors and the resident must have walked out of the facility at the time the fire alarm sounded, and the doors unlocked.
-The RCC informed her that the facility had cameras on the exit doors and did not observe the resident exiting the facility on 08/12/21.
-The family member thought Resident #4 should have been top priority the second the fire alarm sounded because of the resident's history of watching the exit doors.
-The family member contacted the facility approximately at 11:00am on 08/12/21 about another issue and was informed by the RCC that staff could not find the resident and the police had been contacted.
-She could not understand how the resident was able to get ¼ miles away from the facility without staff knowing.
-The family member was concerned how the resident was able to get out because the facility was supposed to have been a secured unit to keep him safe.
-The family member placed the resident at the facility to keep the resident safe.
-On 08/12/21 and 08/13/21, the weather was very hot and very sunny.
-The resident was not found until the next day (08/13/21) unresponsive and covered in fire ant and bee stings on his arms, entire head and lower torso.
-The resident remained hospitalized and was not doing well and was "just hanging on".
-It was possible the resident might not make it through the current health crisis he was currently enduring.
-The resident was currently on a breathing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 270	Continued From page 31	D 270		

machine (ventilator).
-She was not aware of any incident of the resident eloping from the facility prior to 08/12/21.
-She was told by the RCC there was an incident a month or two after the resident was admitted to the facility that the resident tried to get up and out over a wall at the facility but per staff, the resident did not get out.
-The family member learned about the incident from the RCC after she and another family member visited the resident and noticed his foot was swollen and the top of the resident's hand was cut; after questioning the RCC the family member was told the resident tried to get out of the facility.
-The family member was not aware of any supervision interventions or how often staff checked on the resident.

Telephone interview with a Deputy with the local Sheriff's Department on 08/23/21 at 10:48am revealed:
-He was on duty and responded to the facility on 08/12/21 when Resident #4 was reported missing.
-He had spoken with the RCC and she reported that the fire alarm went off and Resident #4 went out the door when the fire alarm went off.
-The RCC estimated that was 30 minutes prior to his arrival.
-The RCC reported Resident #4 liked to stand at the doors to attempt to get out.
-While he was at the facility on 08/12/21, the RCC had showed him the surveillance cameras and Resident #4 was seen walking around the facility at 11:00am walking around however he was unsure of the time on the surveillance camera was correct.
-Staff did not mention to him the time on the surveillance camera was not accurate.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 270	Continued From page 32 -He was told by staff Resident #4 exited the facility possibly at the end of the men's hallway because the resident stood at this door often. -Staff did not report to him that Resident #4 was pulling on the fence in the SCU courtyard around 10:00am on 8/12/21. -On 08/12/21, when Resident #4 eloped from the facility it was very hot that day and responders knew it was important to find him due to concerns of heat exhaustion and dehydration. -The road in front of the facility was a heavily traveled road and was a main roadway leading from a main interstate into the town where the facility was located. -There would have been a risk of an elderly resident with dementia being hit by a car on the road in front of the facility. Interview with the Corporate Nurse on 08/23/21 at 12:11pm revealed: -The exit doors to the facility were kept locked, Resident #4 should have not gotten out. -She saw Resident #4 around 10:00am on 08/12/21, a MA was buttoning his shirt. -Once the fire alarm unlocked the exit doors the staff watched the doors on the halls until the doors were locked and secured. -When we realized Resident #4 was missing all the closets, under beds and the whole facility was searched while others went outside to look for him. -Some of the management staff got in their cars and drove up and down the road looking for Resident #4. -She stayed in the facility and watched the living area where most of the residents were gathered. -The facility was able to meet Resident #4's supervision needs some of the time. -Resident #4 should have had additional supervision.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 270	Continued From page 33 Interview with the Administrator on 08/23/21 at 3:36pm revealed: -Interventions could have been put into place such as "enhanced" supervision, contacting the physicians for medication adjustments, contacting the family to see what they think might help. -Resident #4 was not placed in any increased supervision. Interview with Resident #4's primary care provider (PCP) on 08/23/21 at 1:59pm revealed: -She started seeing Resident #4 a few months ago. -Resident #4 was minimally engaging, restless, not agitated, and wandered. -When Resident #4 eloped on 08/12/21 was the first time she had been made aware that the resident had gotten out of the facility. -She would not want to sedate Resident #4 but if she had known he was getting out or trying to get out she would have adjusted his medication. -Ideally a staff should have been outside when residents were outside. -The resident was in a SCU for a reason. -The resident would not be able to give anyone his address or be able to get back to the facility due to his level of dementia. -When the resident eloped from the facility, the resident could have been hit by a car, fell, broke bones or even died. -The facility would not need an order to increase supervision for the resident. -She expected the facility to meet the supervision needs of the residents in order to keep the resident safe. Telephone interview with Resident #4's mental health provider on 08/23/21 at 2:20pm revealed: -The resident's baseline was minimally engaging	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 270	Continued From page 34	D 270		

and could answer simple yes or no questions.
-The resident did not have agitation and was not violent but was restless and wandered.
-She was aware the resident wandered in other resident's rooms and sat on residents' beds and required redirection from staff.
-Staff had not notified her that the resident had ongoing exit seeking behaviors and she was not notified of any incident prior to 08/12/21 that the resident had gotten out of the facility.
-She was notified by staff on 07/06/21 that the resident was difficult to redirect and was more anxious, agitated and she increased the resident's Seroquel. (Seroquel is a medication used to treat mood and behaviors).
-The resident was in a locked facility to keep him safe.
-She could have made medication adjustments for the resident to have made him more comfortable if he was in enough distress that he was attempting to leave the facility.
-Staff were expected to follow the facility's policy regarding supervision for the residents.
-The facility did not need an order to increase supervision.
-Because residents' residing in a SCU had dementia, "ideally" the residents needed staff supervision when outside in the SCU courtyard.
-She expected staff to ensure supervision needs of residents were met to prevent residents from eloping and keeping the residents' safe,
-Resident #4 was at risk when elopements occurred with just the elements the resident could have been in.
-Resident #4 had dementia, there was no way the resident would have known where to go and would not have been able to tell anyone where he was going or his address; the resident would have been completely lost.
-There were concerns of physical harm when the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 270	Continued From page 35 resident eloped from the facility and the resident would have been at risk of being hit by a car, falling getting hurt, dehydration or death. -She would have expected notification from staff regarding the resident's elopements, if she had known she would have changed what she was doing and placed other interventions in place for the resident. The facility failed to meet the supervision needs of 1 of 6 sampled residents who was diagnosed with dementia and required care in a Special Care Unit in order to keep the residents safe as evidenced by Resident #4 who was known to have wandering and exit seeking behaviors who wandered into other resident's rooms, exited the secured facility unsupervised by staff and on 08/12/21. Resident #4 eloped from the facility and was missing for approximately 20 hours and found in a wooded area by rescue personnel unresponsive, in critical condition, lying down covered in fire ants, bees, leaves and debris which resulted in Resident #4 sustaining a heart attack and a life threatening condition affecting the resident's muscles, ant bites all over his body including his eyes and yellow jacket stings which resulted in the resident requiring hospitalization, dialysis and intubation and diagnoses including acute hypoxic respiratory failure, septic shock secondary to pneumonia and multiorgan failure requiring dialysis. This failure resulted in serious physical harm and serious neglect of the residents and constitutes a Type A1 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/13/21 with and an addendum on 08/19/21. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED SEPTEMBER	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 270	Continued From page 36 22, 2021	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .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: TYPE B VIOLATION Based on interviews, and record reviews, the facility failed to ensure physician notification for 1 of 6 sampled residents (#4) related to a resident of a Special Care Unit (SCU) who had known wandering and exit seeking behaviors and had eloped from the facility. The findings are: Review of Resident #4's current FL-2 dated 04/26/21 revealed: -Diagnoses included dementia, hypertension, schizophrenia with delusions/paranoia, left kidney lesions, vitamin B12 deficiency, history of cerebrovascular accident (CVA) and diastolic dysfunction. -The resident was constantly disoriented and had wandering behaviors. -The resident was ambulatory. -The resident was admitted to the Special Care Unit (SCU) on 04/26/21. Review of Resident #4's current assessment and care plan dated 04/27/21 revealed: -The resident had wandering behaviors. -The resident had "no problems" with ambulation and used no assistance devices.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 273	Continued From page 37	D 273		

-The resident was sometimes disoriented and had significant memory loss, requiring direction.

Review of an incident report for Resident #4 from the county's Sheriff Department dated 08/12/21 revealed:
-On 08/12/21 at 11:22am, a Sheriff's Deputy responded to the facility due to a missing person.
-Observations of the weather was clear, daylight with a temperature of 95 degrees Fahrenheit (F).
-Upon arrival, staff reported Resident #4 had walked away from the facility around 11:00am during a fire alarm.
-It was determined Resident #4 was in the building at 11:00am by reviewing the surveillance cameras.
-During the review of the surveillance cameras, the Deputy was unable to view the recorded surveillance at the facility's exit door cameras.
-The Deputy was advised Resident #4 liked standing at the door, waiting for staff to open the doors so he could get out of the building.
-Two deputies searched the facility to ensure the resident was not hiding in the building.
-K-9 units responded to the location and Emergency Medical Services (EMS) responded to help with the incident.

Review of Resident #4's primary care provider (PCP) visit note dated 06/25/21 revealed:
-The resident was seen as a new admission for primary care services.
-There were no changes in the resident's current order.

Review of Resident #4's PCP visit note dated 08/10/21 revealed:
-The resident was being seen for a physician visit.
-The resident had been clinically and medically at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 273	Continued From page 38	D 273		

baseline with no acute issues.
-There were no new orders provided for this visit.

Review of Resident #4's mental health provider note dated 05/04/21 revealed:
-The resident had a previous diagnosis of dementia, appeared to be vascular in nature given his history of a CVA.
-The resident was pleasantly confused and with noted short and long-term memory deficits today.
-The resident was taking Ativan 1mg every evening and had an as needed Ativan which had not been given so far that month. (Ativan is a medication used to treat anxiety).
-Staff noted the resident was very anxious and restless though cooperative.
-The resident had tried to get out of the fence in the yard when outside.
-The resident's as needed Ativan would be discontinued, and the resident was placed on Ativan 0.5mg twice daily and continue Ativan 1mg every evening.

Review of Resident #4's mental health provider note dated 05/18/21 revealed:
-At the last visit, staff reported that the resident was very anxious and restless.
-The resident's as needed Ativan was discontinued, and the resident was started on Ativan 0.5mg twice daily in addition to Ativan 1mg every evening.
-Staff noted that the resident appeared to be tolerating this well, he was less anxious, but he remained restless at times.
-The resident was seen today resting comfortably in the dayroom.
-There were no changes needed from the visit.

Review of Resident #4's mental health provider note dated 06/01/21 revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 273	Continued From page 39	D 273		

-The resident was restless at times but calm and no agitation or behavioral issues.
-There were no changes needed from the visit.

Review of Resident #4's mental health provider note dated 06/29/21 revealed:
-The resident was pleasantly confused and with noted short and long-term memory deficits today.
-The resident was calm and no agitation or behavioral issues.
-The staff continued to provide supportive care.
-There were no changes needed from the visit.

Review of Resident #4's mental health provider note dated 07/27/21 revealed:
-The resident was pleasantly confused and with noted short and long-term memory deficits today.
-The resident was calm and no agitation or behavioral issues but was often seen walking and wandering around the facility.
-The resident was taking Ativan 0.5mg twice daily in addition to Ativan 1mg every evening for anxiety.
-The resident was taking Seroquel 50 mg three times daily for psychosis which had been increased from Seroquel 50mg daily and 75mg every hour of sleep since the last visit. (Seroquel is a medication used to treat mood and behaviors).
-The resident denied hallucinations and there was no evidence of psychosis.
-The staff denied any concerns with his sleep today, stable at this time.
-There were no changes needed from the visit.

Interview with a PCA on 08/18/21 at 3:53pm revealed:
-She was working a couple of months ago when Resident #4 climbed over the fence.
-Resident #4 put a chair up to the fence and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 273	Continued From page 40	D 273		

climbed over.
-Resident #4 was seen on the outside at the women's hall end door.
-She was not sure who assisted Resident #4 back into the building.
-Residents were to be checked on every two hours.
-PCAs were assigned residents but most of the time the PCAs worked together on their halls checking on the residents

Interview with a personal care aide (PCA) on 08/19/21 at 11:00am revealed:
-Resident #4 was "smart like Houdini".
-There was an incident approximately one month ago when Resident #4 attempted to jump across the fence in the courtyard of the facility however staff saw the resident before he jumped over and got the resident down off the fence in the SCU courtyard.
-She reported the incident to a medication aide (MA).

Telephone interview with the Transporter/PCA on 08/21/21 at 5:23pm revealed:
-She usually saw Resident #4 in the hallways each day when she arrived to work at 8:00am.
-Usually, Resident #4 stood at the door and watched people go in and the resident would attempt to run up to the exit door.
-Resident #4 would attempt to slip out behind staff when the exit doors opened and had to be redirected.
-She had previously observed Resident #4 attempt to climb the fence in the SCU courtyard by placing a chair at the fence and then attempt to climb over.
-She had observed Resident #4 attempting to climb the fence in the courtyard "a couple of times" and would redirect the resident back

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 273	Continued From page 41	D 273		

inside.
-Resident #4 would attempt to climb the fence in the courtyard when there was no staff outside with him and when staff were outside with him.
-She informed the Resident Care Coordinator (RCC) when she saw Resident #4 attempting to get out of the facility by going over the fence in the SCU courtyard.
-Resident #4 was a very strong man (physically) and had attempted to get out so much that he "stayed at the fence trying to get out" and would drag chairs back out of the facility and into the SCU courtyard.
-She was informed by other staff Resident #4 had made a "hole" in the fence in the SCU courtyard.
-Resident #4 constantly tried to get out of the facility, he was an exit seeker.

Telephone interview with a MA on 08/19/21 at 5:25pm revealed:
-Resident #4 had broken the SCU's courtyard fence twice.
-The first time Resident #4 placed a chair at the SCU courtyard at the fence and climbed over the fence which caused the fence to break.
-She was not working at the time Resident #4 initially crawled over the fence, but she came in for the evening shift the same day the incident occurred and was told by other staff.
-She was aware of an incident when Resident #4 kept pulling on the fence to get out of the facility but at that time the chairs In the SCU courtyard had been removed to prevent the resident from climbing over.
-Staff redirected Resident #4 when he pulled on the fence in the SCU courtyard.

Interview with the Assistant Resident Care Coordinator (RCC) on 08/23/21 at 9:32am revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 273	Continued From page 42 -She was made aware on 07/17/21 at 7:23pm that Resident #4 had knocked a portion of the outside fence down. -She was not aware of any other time he had gotten out the facility. Confidential interviews with a staff revealed: -Resident #4 got out the facility the 1st time and was seen by someone outside of the facility. -The facility was notified that a resident was outside on the highway. -A staff went out and brought Resident #4 back into the facility. -Resident #4 got out a 2nd time by climbing over the fence by putting a chair up to the fence. -Resident #4 was seen by staff and someone went out and brought him back into the facility. Confidential interview with a second staff revealed: -She was aware Resident #4 had gotten out of the facility before 08/12/21. -Resident #4 climbed over the fence by putting a chair up to the fence. Interview with a neighbor in the surrounding community on 08/23/21 at 8:12am revealed: -There was an incident approximately a few months ago when the neighbor had observed Resident #4 on the outside of the facility without staff. -The neighbor could not remember the exact day but knew the incident occurred on a weekday in the afternoon and the weather was sunny and warm that day. -The neighbor noticed Resident #4 walking toward the highway in front of the facility on the left side of a church located next to the facility (on the opposite side of the church next to the facility).	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 273	Continued From page 43	D 273		

-Resident #4 walked beside the road in front of the facility and passed the front of the facility.
-The neighbor did not realize it was a resident at the facility at that time and thought it was someone who was intoxicated by the way the resident was walking.
-The neighbor watched the resident because of concerns he was walking too close to the busy road.
-Resident #4 turned in his direction of walking at the side road next to the facility and almost fell when he started turning.
-The neighbor contacted the facility and asked staff if they were missing any residents.
-Two staff members came to the road where Resident #4 was walking and picked the resident up on a van.
-The neighbor knew it was Resident #4 that was observed walking down the road because the resident was recognized as the same resident seen on television on 08/12/21 when a silver alert was issued.

Interview with the RCC on 08/19/21 at 3:47pm revealed she was aware Resident #4 attempted to exit the facility one time however staff had never notified her the resident had exited out of the facility.

Interview with the RCC on 08/23/21 at 2:40pm revealed:
-She was aware Resident #4 had shaken the fence out in the courtyard.
-She was not aware Resident #4 had gotten out previously (before 08/12/21).
-In June 2021 Resident #4 was seen standing on a chair at the fence.
-She brought the chairs inside from the courtyard.
-She did not contact Resident #4's PCP or mental health provider.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 273	Continued From page 44	D 273		

-She was unable to provide a reason why she did not contact Resident #4's PCP or mental health provider to report Resident #4's exit seeking behavior.
-Staff were expected to report any behaviors or elopements to the her, the RCC Assistant, the Corporate Nurse or the Administrator immediately.
-She expected staff to notify the PCP or mental health provider immediately of any exit seeking behaviors or possible elopements.

Interview with the Administrator on 08/23/21 at 3:36pm revealed:
-He was aware Resident #4 had gotten out one time before by jumping over the fence.
-He would expect to be notified if Resident #4 was getting out or trying to get out of the facility.
-Interventions could have been put into place such as contacting the physicians for medication adjustments if the ongoing exit seeking behaviors and elopement prior to 08/12/21 had been reported to Resident #4's providers.

Interview with the Regional Director on 08/23/21 at 4:00pm revealed:
-His expectation was for the MA to report any elopement or exit seeking behavior to the RCC and then report it to him.
-He had to find out where the break down was and ensure the residents' safety.
-There was an incident when the RCC notified him that Resident #4 had tried to get out and wanted to take the chairs out of the courtyard.
-The Assistant RCC sent him a picture of the broken courtyard gate and he called her and asked how Resident #4 broke the gate.
-His concern was that staff had not notified him concerning Resident #4's previous elopements.
-Resident #4's PCP and the mental health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 273	Continued From page 45	D 273		

provider should have contacted by the RCC, Assistant RCC or the MA immediately when there was an incident of an elopement.

Interview with Resident #4's PCP on 08/23/21 at 1:59pm revealed she had not been notified the resident had eloped from the facility prior to 08/12/21.

Telephone interview with Resident #4's mental health provider on 08/23/21 at 2:20pm revealed:
-Staff had not notified her that the resident had ongoing exit seeking behaviors and she was not notified of any incident prior to 08/12/21 that the resident had gotten out of the facility.
-Staff notified her on 07/06/21 that the resident was difficult to redirect and was more anxious, agitated; she increased the resident's Seroquel.
-It would have been helpful for her to have known the resident had eloped prior to 08/12/21 in order to treat the resident.
-She could have made medication adjustments to keep the resident more comfortable if he was in enough distress that he was attempting to leave the facility.
-She would have expected staff to notify her regarding the resident's elopements, she could have changed what she was doing and placed other interventions in place for the resident.

_____

The facility failed to notify the primary care provider and or the mental health provider concerning Resident #4's patterned exit seeking behaviors and at least one elopement incidence prior to 08/12/21 which prevented treatment and interventions for the resident to reduce behaviors and resulted in an elopement. The facility's failure was detrimental to the health, safety and welfare of the resident and constitutes a Type B Violation.

_____

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 273	Continued From page 46 The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/23/21. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 07, 2021	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to implement physician orders for 1 of 5 sampled residents with orders for daily blood pressure checks for 14 days. The findings are: Review of Resident #2's FL2 dated 06/3/21 revealed diagnoses included vascular dementia with behavioral disturbance, debility, essential hypertension, type 2 diabetes mellitus with hyperglycemia, coronary artery disease chronic pain syndrome, history of cerebrovascular accident, and primary osteoarthritis. Review of Resident #2's Primary Care Provider (PCP) visit report dated 07/22/21 revealed: -Per staff the resident reported dizziness and not feeling well.	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 276	Continued From page 47 -The resident's blood pressure reading was 183/89. -The resident denied chest pain, headaches, and shortness of breath. -The resident had history of hypertension. -The resident reported intermittent dizziness. -The resident had history of cerebrovascular accident (CVA). -The CVA was in September 2020 and resulted in hospitalization and rehabilitation. -There was an order to start Norvasc 2.5mg every night. (Norvasc is a medication used to treat high blood pressure). -There was an order to start daily blood pressure checks for 14 days and record on the electronic medication administration record (eMAR). -Diagnoses included cerebral infarction unspecified and essential primary hypertension. Review of Resident #2's eMAR for July 2021 revealed there was no line entry for daily blood pressure checks for 14 days. Review of Resident #2's eMAR for August 2021 revealed there was no line entry for daily blood pressure checks for 14 days. Review of Resident #2's eMAR for August 2021 revealed: -There was a line entry for daily blood pressure checks added on 08/19/21, record the reading on the eMAR, and report a blood pressure reading over 180/100. -There was a blood pressure reading of 133/87 at 8:00am. -There was no documented blood pressure reading of 186/70 from today at 3:38pm and no notification to the PCP. Interview with the Assistant Resident Care	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 276	Continued From page 48 Coordinator (RCC) on 08/19/21 at 1:00pm revealed: -She faxed the order to the pharmacy for daily blood pressure checks for Resident #2. -There was no line entry on the MAR for daily blood pressure checks. -The RCC told her today that the pharmacy never received the order. Interview with the RCC on 08/19/21 at 1:13pm revealed: -She called the pharmacy and the order for daily blood pressure checks for 14 days for Resident #2 was never received. -She would notify the PCP. Second interview with the Assistant RCC on 08/20/21 at 10:22am revealed: -When the PCP was in the facility to see residents, she left any new medication orders or she would have her practice to fax the order to the facility. -Once the order was received from the PCP she faxed it to the pharmacy. -She documented when the order was faxed. -She faxed the order for daily blood pressure checks for Resident #2 to the pharmacy. -There was no line entry for daily blood pressure checks on the eMAR. -The RCC told her the pharmacy said it was never received. -She was sure she faxed it. -She received a confirmation page showing it was faxed. -She did not have the confirmation page. Second interview with RCC on 08/20/21 at 11:55am revealed: -The medication ordering process was to send a copy of the order to the pharmacy via fax or the	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 276	Continued From page 49	D 276		

pharmacy would receive the order from the PCP via escribe (electronic prescription).
-The pharmacy placed the medication on the eMAR and delivered the medication.
-The Assistant RCC was supposed to fax the order for the daily blood pressure checks for Resident #2 to the pharmacy.
-The Assistant RCC did not realize that the order for Resident #2's blood pressure medication also had an order for daily blood pressure checks for 14 days.
-The Assistant RCC should have followed up the next day to see if the order was on the eMAR.
-The pharmacy added daily blood pressure checks to the eMAR for Resident #2 on 08/19/21.

Telephone interview with the facility pharmacist on 08/20/21 at 1:02pm revealed:
-She received the order for daily blood pressure checks for 14 days for Resident #2 on 8/19/21.
-The daily blood pressure checks were added to the MAR.

Second interview with the Assistant RCC on 08/20/21 at 3:35pm revealed she checked Resident #2's blood pressure today and the reading was 186/70.

Observation of Resident #2 on 08/20/21 at 3:38pm revealed:
-The Assistant RCC checked the resident's blood pressure.
-The resident's blood pressure reading was 186/70.

Telephone interview with the PCP on 08/20/21 at 4:13pm revealed:
-She started Resident #2 on daily blood pressure checks for two weeks on 07/22/21 to make sure the new blood pressure medication was helping

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 276	Continued From page 50 her blood pressure and to ensure it was not going to low. -The facility had blood pressure parameters to contact her if Resident #2's blood pressure was over 180/100. -She did not received a report today regarding Resident #2's blood pressure reading of 186/70. -The daily blood pressure checks were only for two weeks. -The expectation was for the facility to monitor Resident #2's blood pressure when ordered.	D 276		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to serve therapeutic diets as ordered by the primary care provider (PCP) for 2 of 5 sampled residents who had diet orders for a low concentrated sweet (LCS) diet with a pureed consistency and nectar thickened liquids (#1 and #6) and supplemental nutritional shakes (#1). The findings are: 1. Review of Resident #1's current FL-2 dated	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 310	Continued From page 51	D 310		

07/27/21 revealed diagnoses included dementia, psychosis, Parkinson disease, and type II diabetes.

Review of a signed diet communication order for Resident #1 dated 04/14/21 revealed a low concentrated sweets (LCS) diet with a pureed consistency, nectar thick liquids and supplemental nutritional shakes.

Review of the residents' diet list posted in the kitchen on 08/18//21 revealed Resident #1 was to be served a LCS, no added salt diet with a pureed consistency, nectar thickened liquids and supplemental nutritional shakes three times daily.

Review of the facility's therapeutic menus revealed:
-There was no LCS therapeutic menu for the guidance of the dietary staff available.
-There was a pureed, regular/no added salt (NAS) menu.
-There were instructions a NAS diet was a regular diet with the salt shaker removed from the table.

Review of the therapeutic menu for a pureed, regular/NAS for the residents' lunch meal on 08/19/21 revealed three ounces of pureed classic baked ham, pureed mashed yams, pureed loaded cauliflower, one pureed roll and one pudding.

Observation of Resident #1 during lunch in her room on 08/19/21 between 12:30pm and 1:00pm revealed:
-Resident #1 was being fed by a personal care aide (PCA).
-Resident #1 had pureed greens that were thin and watery.
-Resident #1 had pureed ham that was not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 310	Continued From page 52	D 310		

smooth and had chunks of ham in it.
-Resident #1 had water that was not nectar thick consistency that she drank ¾ of
-Resident #1 had tea that was not nectar thick consistency that she drank ¾ of.
-Resident #1 had a carton of milk that she did not drink.
-Resident #1 had a supplement nutrition shake in the carton and she drank all of it that was not nectar thick consistency.
-There was no coughing noted.

Review of the therapeutic menu for a pureed, regular/NAS for the residents' lunch meal on 08/20/21 revealed two pureed meatballs, pureed lime cilantro rice, pureed country trio medley, one pureed roll and one slice of pureed marble loaf cake.

Observation of Resident #1 during lunch in her room on 08/20/21 between 1:05pm and 1:30pm revealed:
-Resident #1's water was not nectar thick consistency.
-The PCA took the water back to the kitchen to be thickened after prompting.
-When the PCA returned to Resident #1's room the water was a nectar thick consistency.

Interview with the PCA on 08/19/21 at 1:24pm revealed:
-Resident #1's was to have thickened liquids.
-Resident #1's water and tea were loose, not nectar thick.
-Resident #1 had supplemental shake from the carton that was not nectar thick.
-She has had to take the liquids back occasionally to be thickened.
-She could not remember the last time Resident #1's liquids had to be taken back to the kitchen to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 310	Continued From page 53	D 310		

be thickened more.

Interview with Resident #1's primary care provider (PCP) on 08/20/21 at 4:12pm revealed:
-Residents on the thickened liquids and puree diets was usually due to disease process progressing which can cause difficulty swallowing.
-The residents would be placed as risk for aspiration if not given the correct thickened liquids and pureed diet.
-The facility had a list of therapeutic diets offered, if a LCS was not available then it should have been removed from the therapeutic diets offered.

Based on observations, interviews and record reviews it was determined Resident #1 was not interviewable.

Refer to the observation of the labeled instructions on the container of a thickening agent in the kitchen on 08/19/21 at 12:04pm.

Refer to the observation of the Dietary Manager (DM) on 09/18/19 at 12:04pm.

Refer to the interview with the DM on 08/19/21 at 12:50pm.

Refer to the second interview with the DM on 08/20/21 at 1:17pm.

Refer to the interview with the Resident Care Coordinator (RCC) on 08/22/21 at 2:40pm.

Refer to the interview with the Assistant RCC on 08/23/21 at 9:32am.

Refer to the interview with the Corporate Nurse on 08/23/21 at 12:17pm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 310	Continued From page 54 Refer to the interview with the Administrator on 08/23/21 at 3:36pm. Refer to the interview with the Regional Director on 08/23/21 at 4:00pm. 2. Review of Resident #6's current FL-2 dated 08/16/21 revealed: -Diagnoses included vascular dementia, cerebrovascular accident with residual weakness, diabetes, hypertension, degenerative joint disease, chronic low blood pressure, Crohn's disease, chronic obstructive pulmonary disease. -There was an order for a low concentrated sweets (LCS), no added salt (NAS) diet with a pureed consistency and nectar thickened liquids. Review of the residents' diet list posted in the kitchen on 08/18//21 revealed Resident #6 was to be served a LCS, no added salt diet with a pureed consistency and nectar thickened liquids. Review of the facility's therapeutic menus revealed: -There was no LCS therapeutic menu for the guidance of the dietary staff available. -There was a pureed, regular/NAS menu. -There were instructions a NAS diet was a regular diet with the saltshaker removed from the table. Review of the therapeutic menu for a pureed, regular/NAS for the residents' lunch meal on 08/19/21 revealed three ounces of pureed classic baked ham, pureed mashed yams, pureed loaded cauliflower, one pureed roll and pudding. Observation of Resident #6 during the lunch meal on 08/19/21 between 12:25pm - 12:40pm revealed:	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 310	Continued From page 55	D 310		

-Resident #6 was served pureed greens with a thin, watery liquid, pureed ham that was not smooth with small chunks of ham, one pudding cup, pureed yams and 8 ounces of tea that appeared to be in a nectar thick consistency.
-At 12:38pm, Resident #6 had eaten all the plated food except for 50 percent of the pureed greens in the thin watery liquid and 75% of the tea that appeared to be in a nectar thickened consistency.
-There was no coughing noted.

Observation of the Dietary Manager (DM) on 08/19/21 at 12:38pm revealed:
-After being prompted by the surveyor, the DM added approximately 1 teaspoon of the powdered thickening agent to Resident #6's plated greens and stirred the greens until the powder was dissolved.
-The plated greens were in a pudding like consistency with no thin watery liquid remaining.

Telephone interview with Resident #6's family member on 08/23/21 at 10:05am revealed:
-The resident had been on thickened liquids and pureed foods for years due to swallowing difficulties from a cerebrovascular accident.
-The resident "pockets food" and ate fast.
-The resident hated pureed foods.
-The family member had taken the resident out of the facility for visits and allowed the resident to have foods cut up instead of pureed and the resident did not have any problems with choking or coughing.
-The resident could not have thin liquids because she had decreased ability to swallow.

Interview with Resident #6's primary care provider (PCP) on 08/20/21 at 4:12pm revealed:
-Residents on the thickened liquids and puree diets was usually due disease process

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 310	Continued From page 56 progressing which can cause difficulty swallowing. -The facility had a list of therapeutic diets offered, if a LCS was not available then the diet should have been removed from the therapeutic diets offered. Based on observations, interviews and record reviews Resident #6 was not interviewable. Refer to the observation of the labeled instructions on the container of a thickening agent in the kitchen on 08/19/21 at 12:04pm. Refer to the observation of the DM on 09/18/19 at 12:04pm. Refer to the interview with the DM on 08/19/21 at 12:50pm. Refer to the second interview with the DM on 08/20/21 at 1:17pm. Refer to the interview with the Resident Care Coordinator (RCC) on 08/22/21 at 2:40pm. Refer to the interview with the Assistant RCC on 08/23/21 at 9:32am. Refer to the interview with the Corporate Nurse on 08/23/21 at 12:17pm. Refer to the interview with the Administrator on 08/23/21 at 3:36pm. Refer to the interview with the Regional Director on 08/23/21 at 4:00pm. _____ Observation of the labeled instructions on the container of a thickening agent in the kitchen on	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 310	Continued From page 57 08/19/21 at 12:04pm revealed: -There was a large container of a powdered thickening agent. (A thickening agent is a powder that is dissolved in liquids to thicken thin liquids to a desired consistency when thin liquids were difficult to swallow, to prevent choking and prevent liquids from entering the lungs during the swallowing process). -There was a dual ended blue measuring device inside of the container. One end was labeled as one tablespoon and the other end labeled one teaspoon. -There were labeled directions including "t" = teaspoon, "T" = tablespoon and instructions there were 3 teaspoons in one tablespoon. -The manufacturer's label had directions for a nectar thick consistency to add 3½ - 4 teaspoons (t) to water, apple juice. cranberry juice, and coffee/tea, 4t - 4 ½t to low fat milk and nutritional drink supplements and 3t - 3½t to orange juice, to every 4 ounces of liquid. -One T of the thickening agent should be added to 4 ounces of food when pureeing. -There were instructions that the amount of the thickening agent used may need to be adjusted to suit the thickness requirements. Observation of the DM on 09/18/19 at 12:04pm revealed: -The DM poured tea into a measuring cup and measured 8 ounces of tea with no ice, then poured the tea into a beverage cup. -The DM added one tablespoon and 2 teaspoons of the thickening agent using the measuring device in the thickening agent container to the 8 ounces of tea for a total of 5t. -The DM did not refer to the labeled manufactured instructions for nectar thick liquids. -The DM stirred the thickening agent that was added to the tea until dissolved and verbalized	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 310	Continued From page 58	D 310		

the 8 ounces of tea was at nectar consistency and was ready to be served to the resident.
-The tea was not in a nectar thick consistency.
-The DM was prompted to refer to the labeled manufactured instructions.
-The DM added an additional 2t to the tea in the beverage container and stirred the thickening agent that was added to the tea until dissolved.
-The 8 ounces of tea was in a nectar consistency.

Interview with the DM on 08/19/21 at 12:50pm revealed:
-She had worked at the facility for 10 years as a personal care aide (PCA) and in dietary.
-Dietary staff were responsible for preparing the powdered thickening agent for the residents with orders for thickened liquids during meals.
-She was trained how to mix thickened liquids "years ago' by a nurse.
-She had written instructions she followed when preparing the residents' thickened liquids.
-For tea, water, milk and all juices except orange juice she added "1 big scoop' and 2 little scoops" of the thickening agent (referring to the dual ended blue measuring device inside of the container labeled as one tablespoon and the other end labeled one teaspoon).
-She currently could not locate her written instructions for preparing the thickener but knew the amount of thickener she added was dependent on the liquid the thickening agent was prepared in.
-She was not sure what the measurements were for the dual ended blue measuring device inside of the container.
-She did not reference the labeled manufactured instructions when preparing the residents' thickened liquids with the thickening agent, she should have but forgot to do so.
-She knew nectar thickened liquids were slightly

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 310	Continued From page 59	D 310		

thickened and would coat or cling to a spoon leaving a thin stream when poured off the spoon.
-Pureed foods should be in a smooth baby food consistency, not runny and with no liquids.
-She added the thickening agent to foods when there was too much water in foods after pureeing.
-She thought the water content in the greens had separated from the greens during the residents' lunch meal on 08/19/21.
-There was a lot of water content in foods such as leafy greens.
-She did not puree the ham served to the residents today, (08/19/21).
-A dietary staff prepared the pureed ham.
-The ham served to the residents during the lunch meal should have been pureed into a smooth consistency instead of chunky.
-She was responsible for training dietary staff how to prepare ordered modified textures such as pureed and mechanical soft foods.
-She was responsible for training dietary staff how to prepare thickened liquids for the residents.
-She had not trained all current dietary staff because some were already trained upon hire.
-The Resident Care Coordinator (RCC) and the Administrator observed foods prepared and served to the residents (no frequency provided).

Second interview with the DM on 08/20/21 at 1:17pm revealed:
-The Regional Director (RD) or the Administrator printed and provided dietary staff with the weekly therapeutic menus.
-When she prepared and served a low concentrated sweets (LCS) diet to the residents she served ½ of the menus serving size for the dessert.

Interview with the RCC on 08/22/21 at 2:40pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 310	Continued From page 60	D 310		

-The Assistant RCC updated the diet list with any new orders.
-The Assistant RCC would update the dietary staff and post the new dietary orders.
-The DM was responsible for making the dietary staff aware of the new orders.
-She would go into the dining room and help pass out trays.
-She would make sure the liquids were the right consistency for the residents with thickened liquids.
-She had not noticed any problems with the thickened liquids.
-She also looked at the pureed diets but had never seen anything concerning.
-If the thickened liquids and the puree diets were not correct the residents could choke.
-She was not aware there was no LCS diet menu for the dietary manager to follow.

Interview with the Assistant RCC on 08/23/21 at 9:32am revealed:
-Residents were put on thickened liquids and puree diets due to them not being able to swallow.
-She was not aware of any coughing and choking for the residents on thickened liquids and puree diets.

Interview with the Corporate Nurse on 08/23/21 at 12:17pm revealed:
-She had recently observed the DM prepare the residents nectar thickened liquids and had to provide some guidance to the DM when she prepared the nectar thickened liquids.
-The preparation and mixing instructions were labeled on the thickening agent's container.
-It was important to prepare and serve all food to the residents as ordered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 310	Continued From page 61 Interview with the Administrator on 08/23/21 at 3:36pm revealed: -The Assistant RCC was responsible for diet orders and changes. -She was to make sure the diet orders were updated and posted in the kitchen so the staff could see. -He monitored the thickened liquid. -He took the directions from the thickener can and scanned them and increased the size so the dietary staff would be able to see them better. -Thickener was used for residents who had trouble swallowing. -Pureed food needs to be consistency of applesauce. -He thought the facility had moved to a LCS diet across the board for all residents. -The Regional Director (RD) printed the menus. Interview with the RD on 08/23/21 at 4:00pm revealed: -The facility had a therapeutic diet for LCS for dietary staff to follow. -The DM was able to access the LCS menu from the outside provider's dietary webpage. -He expected all therapeutic diets to be served as ordered.	D 310		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE B VIOLATION	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 338	Continued From page 62	D 338		

Based on observations, interviews and record reviews, the facility failed to ensure 1 of 5 sampled residents (#2) in the Special Care Unit (SCU) felt safe in her room with a male resident entering her room 3-4 times a day and night.

The findings are:

Review of Resident #2's FL2 dated 06/03/21 revealed diagnoses included vascular dementia with behavioral disturbance, debility, essential hypertension, type 2 diabetes mellitus with hyperglycemia, coronary artery disease chronic pain syndrome, history of cerebrovascular accident, and primary osteoarthritis.

Review of a shift report for 06/06/21 from 7:00pm - 7:00am revealed:
-There was documentation that a male resident went into Resident #2's room.
-The male resident was eating Resident #2's food that was in her room.
-Resident #2 was scared to be in her room alone.

Review of Resident #2's psychiatry progress note dated 08/10/21 revealed:
-Resident #2 stated her mood was okay unless "I have to deal with that man [a male resident]."
-Resident #2 had been focused recently on a confused peer who wandered into her room.
-Resident #2 called the police a few times about a male resident coming into her room.
-Staff recently moved her to another room and she said that the male resident had not come into her room since she was moved.

Interview with a resident on 08/18/21 at 9:30am revealed:
-The male resident came in her room.
-The male resident would lay in her bed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 338	Continued From page 63 -She was afraid of the male resident. Interview with a second resident on 08/18/21 at 9:32am revealed: -The male resident went in everyone's room. -The male resident scared the female residents. -The male resident would lay in everyone's bed and "they [management] did not do much about it." -The male resident went through "people's stuff." Interview with Resident #2 on 08/18/21 at 10:04am revealed: -The male resident used to come into her room and she would try to get him out. -The male resident came into her room and closed the door. -The male resident would take her dirty clothes and smell them. -She would have to call someone to get the resident out. -She was afraid of the male resident. -She called the police a couple of times when the male resident came in her room. -The male resident came in her room 3-4 times per day and night. -The male resident would get in her bed and take her food. -She would scream at night and he would tell her not to. -The facility put a lock on her door for about a week to keep the male resident out of her room. Review of shift report dated 07/18/21 on the 6:00pm- 6:00am shift revealed: -Resident #2 wanted to call the police on a named male resident. -Staff told Resident #2 the named male resident was an elderly male with some problems.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 338	Continued From page 64 Confidential interview with a staff member revealed: -The male resident went in everyone's room. -The male resident wandered in and out of rooms picking up other resident's clothes and shoes. -The male resident would have on 5 pair of pants and 3 shirts from going in everyone's room. -She never observed the male resident in anyone's bed. -She heard Resident #2 screaming one day. -She observed the male resident coming down the hall from her room. -Resident #2 was upset that the male resident was in her room. -Resident #2 was afraid of the male resident. -The male resident did not single Resident #2 out as he went in and out of everyone's room. -Resident #2 told management that the male resident came in her room. -Staff were not told to increase supervision of the male resident but she checked on him every few minutes. -They [management] put a lock on Resident #2's door so she could lock it to keep the male resident out. -Resident #2 locked the door when she was inside her room and staff could not get in without her unlocking the door. -It would take Resident #2 2-3 minutes to unlock the door when she was in bed because she was in a wheelchair. -She expressed concern to other staff about not being able to get in Resident #2's room when it was locked. -Resident #2 was upset when the lock was removed because she was in a room with a bathroom and management moved her to a different room with no bathroom. Confidential interview with a second staff member	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 338	Continued From page 65	D 338		

revealed:
-The male resident went into everyone's room.
-The male resident would go in Resident #2's room.
-The male resident went into Resident 2's room at night.
-The male resident did not sleep much at night.
-The male resident would touch her stuff.
-Resident #2 said she was afraid of the male resident.
-Resident #2 never said she was afraid of any other resident.
-She heard Resident #2 scream multiple times a day when the male resident came in her room.
-Resident #2 would yell for help.
-One of the men [maintenance] put a lock on her door because she was complaining of the male resident coming into her room.
-They [management] told the maintenance man to put the lock on the door.
-She had the lock for about 3 weeks - 1 month.
-She had to "run all the way" to the medication aide to get the key to open the door or would just knock on the door and wait for Resident #2 to answer.
-Staff had to knock loud and hard on her door for her to hear and she would ask who was knocking.
-Resident #2 kept her room door locked all day and night.
-Resident #2 was told to leave the room door open during the day but she had a key and would lock the door when she was not in the room.
-It was unknown who gave Resident #2 the key.

Interview with the Corporate Registered Nurse (RN) on 08/20/21 at 10:00am revealed:
-One of the staff on night shift told her Resident #2 had called the police.
-She did not speak with Resident #2 and ask why she had called the police.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 338	Continued From page 66 Second interview with Resident #2 on 08/20/21 at 3:44pm revealed: -The corporate nurse decided a lock was the best way to prevent the male resident from coming into her room. -The Resident Care Coordinator (RCC) was out at the time. -She had a key to lock the door when she left her room. -She believed the Assistant RCC gave her the key. Interview with the Primary Care Provider (PCP) on 08/20/21 at 4:13pm revealed: -Resident #2 did not report that a male resident was wandering in her room or that she felt unsafe. -Resident #2 may have addressed her concerns with psychiatry. -Resident #2 should have felt safe in her home [facility]. -Resident #2's anxiety could increase if she felt unsafe. Interview with the Administrator on 08/23/21 at 3:36pm revealed: -He was not aware Resident #2 was scared and did not feel safe. -He should have been notified of Resident #2 not feeling safe. -His concerns would be if Resident #2 was locking herself in her room then there was a problem. -He did not review the shift reports. -He did not know if anyone reviewed the shift reports. _____ The facility failed to protect the rights of one resident (#2) by not providing an environment	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 338	Continued From page 67 where the resident felt safe and not scared in her room due to a male resident entering her room 3-4 times a day and night and eating her food, plundering through her belongings. Resident #2 was fearful and called the police twice in one night. The facility's failure to protect resident's rights was detrimental to health safety and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/19/21 for this violation. THE DATE OF CORRECTION FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 7, 2021.	D 338		
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: TYPE B VIOLATION Based on observation, interviews, and record reviews, the facility failed to administered medications as ordered and in accordance with the facility's policies for 1 of 5 residents (#2) related to a medication used to decrease blood	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 68 pressure. Review of Resident #2's FL2 dated 06/03/21 revealed diagnoses included vascular dementia with behavioral disturbance, debility, essential hypertension, type 2 diabetes mellitus with hyperglycemia, coronary artery disease chronic pain syndrome, history of cerebrovascular accident, and primary osteoarthritis. Review of Resident #2's Primary Care Provider (PCP) visit report dated 07/22/21 revealed: -Per staff the resident reported dizziness and not feeling well. -The resident's blood pressure reading was 183/89. -The resident denied chest pain, headaches, and shortness of breath. -The resident had history of hypertension. -The resident reported intermittent dizziness. -The resident had history of cerebrovascular accident (CVA). -There was an order to start Norvasc 2.5mg every night. (Norvasc is a medication used to treat high blood pressure). -Diagnoses included cerebral infarction unspecified and essential primary hypertension. Review of Resident #2's electronic medication administration (eMAR) for July 2021 revealed there was no entry for Norvasc 2.5mg every night. Review of Resident #2's eMAR for August 2021 revealed there was no entry for Norvasc 2.5mg every night. Observation of Resident #2's medications on 08/19/21 at 1:00pm revealed Norvasc 2.5 mg was not available.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 69 Interview with the Assistant Resident Care Coordinator (RCC) on 08/19/21 at 1:00pm revealed: -The Norvasc for Resident #2 was ordered on 07/22/21 when he was seen by the PCP. -She faxed the order to the pharmacy. -The Norvasc was not listed on the MAR. -The facility never received the Norvasc from the pharmacy. Interview with the RCC on 08/19/21 at 1:13pm revealed she called the pharmacy today and the order for Norvasc for Resident #2 was never received. Second interview with the Assistant RCC on 08/20/21 at 10:22am revealed: -When the PCP was in the facility to see residents, she left any new medication orders or she would have her practice to fax the order to the facility. -Once the order was received from the PCP she faxed it to the pharmacy. -She documented when the order was faxed. -The medication was delivered on the same day often at night. -She faxed the order for Norvasc 2.5mg for Resident #2 to the pharmacy and it was supposed to be delivered that night. -She could not recall if the Norvasc was delivered but stated "obviously it did not come." -The RCC told her yesterday the pharmacy said it was never received. -She was sure she faxed it. -She received a confirmation page showing it was faxed. -She did not have the confirmation page. -She did not follow up with the pharmacy to check the status of the faxed Norvasc order. -She did not check to see if the Norvasc was	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 70	D 358		

delivered.
-The RCC notified the pharmacy yesterday of the error and the Norvasc was delivered last night and administered to Resident #2.

Second interview with RCC on 08/20/21 at 11:55am revealed:
-The medication ordering process was to send a copy of the order to the pharmacy via fax or the pharmacy would receive the order from the PCP via escribe (electronic prescription).
-The pharmacy placed the medication on the MAR and delivered the medication.
-The Assistant RCC was supposed to fax the order for Norvasc for Resident #2 to the pharmacy.
-The Assistant RCC should have followed up the next day to see if the new medication was on the eMAR.
-Resident #2's blood pressure reading of 183/89 could have caused a "stroke or anything".
-The medication was delivered last night and administered.

Telephone interview with the facility pharmacist on 08/20/21 at 1:02pm revealed:
-The facility faxed the medication order to the pharmacy and it was placed in a queue.
-The orders were processed and checked by the pharmacist.
-The orders were filled and delivered to the facility the same day for new orders if received by 5:00pm.
-Orders were also received electronically from the PCP and the pharmacy would fax a copy to the facility to ensure the facility had a copy.
-Once the order was filled a line entry for the medication was placed on the eMAR.
-The facility had to approve the new medication or reject it in order for it to show up on the eMAR.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 71 -The order for Norvasc 2.5mg for Resident #2 was never received prior to yesterday 08/19/21. -If Resident #2 did not take the Norvasc, she could have increased blood pressure. Second interview with the Assistant RCC on 08/20/21 at 3:35pm revealed: -She checked Resident #2's blood pressure and the reading was 186/70. -Resident #2's blood pressure read high because she had just smoked a cigarette. Observation of Resident #2 on 08/20/21 at 3:38pm revealed: -The Resident Care Coordinator Assistant checked the resident's blood pressure. -The resident's blood pressure reading was 186/70. Telephone interview with the PCP on 08/20/21 at 4:13pm revealed: -She started Resident #2 on a new blood pressure medication Norvasc 2.5mg at bedtime. -She was not aware until yesterday or today that she was not receiving it. -"If her blood pressure was to go up too high, she could have a stroke, heart attack, headaches, or dizziness." -The expectation was for the facility to start Resident #2 on the medicine and monitor her blood pressure. -She had not been notified of Resident #2's blood pressure reading of 186/70. _____ The failure of the facility to administer blood pressure medication to Resident #2 in accordance with the physician's order to treat and prevent high blood pressures placed the resident at risk of having high blood pressure which can result in headaches and dizziness and put her at	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 72 increased risk of having a stroke or heart attack from uncontrolled blood pressure for a resident diagnosed with essential hypertension and history of cerebrovascular accident. The facility's failure was detrimental to the health of Resident #2 and constitutes a Type B Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 08/18/21. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 07, 2021	D 358		
D 406	10A NCAC 13F .1009(b) Pharmaceutical Care 10A NCAC 13F .1009 Pharmaceutical Care (b) The facility shall assure action is taken as needed in response to the medication review and documented, including that the physician or appropriate health professional has been informed of the findings when necessary. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to follow up on pharmacy review recommendations for 1 of 5 sampled residents (#3). The findings are: Review of Resident #3's FL2 dated 3/10/21 revealed: -Diagnoses included major neurocognitive disorder, history of schizoaffective disorder, bipolar type, generalized anxiety disorder, chronic	D 406		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 406	Continued From page 73	D 406		

lower back pain, hypertension, chronic obstructive pulmonary disease, and glaucoma.
-An order for Mirtazapine 45 mg daily at bedtime.
-An order for Trazadone 50mg daily at bedtime.

Review of a physician's order for Resident #3 dated 07/01/21 revealed an order for Sertraline 100mg daily.

Review of a pharmacy medication issue report for Resident #3 dated 07/05/21 revealed:
-The concern was a drug interaction.
-Additive serotonergic effects may occur during administration of selective serotonin reuptake inhibitors (SSRIs) and Mirtazapine and Trazadone, and the risk of developing serotonin syndrome may be increased.
- Consult the PCP to monitor.
-The medication would be dispensed "please consult prescriber regarding medication issue."
-The PCP did not sign the report.

Interview with the Resident Care Coordinator on 08/19/21 at 11:55am revealed:
-The PCP would have signed the pharmacy medication issue report if she reviewed it.
-She was not aware of the recommendation.

Review of a physician's note for Resident #3 dated 08/19/21 revealed:
-There was no change to the medication orders.
-The report was signed by the PCP.

Interview with the Resident Care Coordinator (RCC) on 08/22/21 at 2:40pm revealed:
-The pharmacy nurse would leave the orders or recommendations with her and she would place them in the primary care provider's (PCP) folder for her to review on her next visit to the facility.
-When she was not at the facility the assistant

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 406	Continued From page 74 RCC was responsible for making sure the recommendations were placed in the PCP's folder for review. -Once the PCP reviewed the papers in the folder, she would give it back to her or the assistant RCC (in her absence) and they were to follow through with any orders. -Record reviews were to be done each month on all residents. -No record reviews had been completed since she was out on leave. -She was out the month on July 2021. Interview with the Administrator on 08/23/21 at 3:36pm revealed when orders were processed, they were faxed to pharmacy. Interview with the Regional Director on 08/23/21 at 4:00pm revealed: -He expected them to follow up with the PCP immediatley. -He did not do any thing with the pharmacy reviews and would have to refer that to the Corporate nurse and the RCC.	D 406		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the residents received care and services that were	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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
D912	Continued From page 75 adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to medication administration, housekeeping and furnishings, residents rights and health care. The findings are: 1. Based on observation, interviews, and record reviews, the facility failed to administered medications as ordered and in accordance with the facility's policies for 1 of 5 residents (#2) related to a medication used to decrease blood pressure. [Refer to Tag D0358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)]. 2. Based on observations, interviews and record reviews, the facility failed to ensure 1 of 5 sampled residents (#2) in the Special Care Unit (SCU) felt safe in her room with a male resident entering her room 3-4 times a day and night. [Refer to Tag D0338, 10A NCAC 13F .0909 Resident Rights (Type B Violation)]. 3. Based on observations, interviews, and record reviews the facility failed to ensure the facility was free of obstructions and hazards including a leaning, unsteady wooden fence and shrub growth in the walkways of the residents' courtyard, personal care hygiene products being stored unlocked in the common shower room on A and B hall and multiple residents' rooms shared and individual bathrooms; and multiple cleaning agents in janitor closets resulting in hazardous substances and chemicals being unattended and accessible to the 34 residents residing in the Special Care Unit (SCU) facility. [Refer to Tag D0079, 10A NCAC 13F .0306(a)(5)	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043033	A. BUILDING: _____ B. WING _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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
D912	Continued From page 76 Housekeeping and Furnishings (Type B Violation)]. 4. Based on interviews, and record reviews, the facility failed to ensure physician notification for 1 of 6 sampled residents (#4) related to a resident of a Special Care Unit (SCU) who had known wandering and exit seeking behaviors and had eloped from the facility. [Refer to Tag D0273, 10A NCAC 13F .0902(b) Health Care (Type B Violation)].	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents were free of neglect as related to supervision. The findings are: Based on observations, interviews and record reviews, the facility failed to provide supervision according to needs of 1 of 6 sampled residents residing in a Special Care Unit (SCU) for a resident who had a history of wandering, elopement and exit seeking behaviors who eloped from the facility (#4). [Refer to Tag D0270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation)].	D914		