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 _____	R 11/23/2021

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 conducted a follow-up survey on 11/22/21- 11/23/21.	{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: FOLLOW-UP TO TYPE B VIOLATION. Based on these findings, the previous Type B Violation was not abated. Based on observations and interviews the facility failed to ensure the facility was free of hazards in three common bathrooms where personal care hygiene products, razor blades, a cleaning product containing bleach, hand sanitizers, and hand soap were left unsecured, unattended, and accessible to 27 residents in the Special Care Unit (SCU). The findings are: Observation of hallway A of the SCU common handicapped shower room on 11/22/21 at 9:04 am revealed: -This room was located mid-way down on the right side of the hallway. -Resident rooms were located on both sides of the common shower room.	{D 079}		

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{D 079}	Continued From page 1 -The door to the common handicapped shower room was unlocked, cracked open and easily accessed. -A red and black metal storage wall cabinet was unlocked and partially opened. -There was one 1 quart bottle of leave-on conditioner that was 1/4 full. -The leave-on conditioner bottle label included a caution the product was for external use only. -There was one 12 ounce bottle of hair conditioner that was 3/4 full. -The hair conditioner bottle label included a warning label to avoid contact with eyes and in case of contact with eyes; rinse immediately. -There was one 3.2 ounce bottle of body spray that was 2/3 full. -The body spray label included a warning to avoid spraying in eyes. -There was one 6.67 ounce can of body spray. -The body spray can label included a caution to not spray near eyes, face or broken skin. -There was one 11 ounce can and one 10 oz can of shaving cream. -The shaving cream can labels cautioned to not puncture or incinerate because contents are under pressure. -There was one 6 ounce can of deodorant spray. -The deodorant spray can label included warnings to keep away from face and mouth, to avoid breathing in the product, and avoid spraying in eyes. -The deodorant spray can label included an additional warning to use only as directed, intentional misuse by deliberately ingesting or inhaling the contents can be harmful or fatal, and if swallowed get medical help or call a Poison Control Center right away. Observation of hallway A of the SCU common handicapped bathtub room on 11/22/21 at 9:08	{D 079}		

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{D 079}	Continued From page 2	{D 079}		

am revealed:
-This room was located mid-way down on the left side of the hallway.
-Resident rooms were located on both sides of the common shower room.
-The door to the common handicapped shower room was unlocked and easily accessed.
-There was a 25 oz pump bottle of antibacterial foam hand soap on top of the paper towel dispenser.

Observation of hallway A of the SCU on 11/22/21 from 9:00am-9:30am revealed three residents walked nearby to the unlocked common handicapped shower room and bathtub room without staff supervision, but no residents entered the rooms.

Interview with the Activity Director (AD) on 11/22/21 at 9:25am revealed:
-All SCU residents were capable of wandering into unlocked rooms.
-It was expected that all storage areas containing any personal hygiene care products be locked when not directly supervised by staff.

Interview with a medication aide (MA) on 11/22/2021 at 9:30 am revealed:
-She was not aware hygiene products were stored in the unlocked wall cabinet in the common handicapped shower room.
-She was not aware of the foam hand soap on top of the towel dispenser in the common handicapped bathtub room.
-She was not aware the foam soap was on top of the towel dispenser in the
-She was not sure of how the products should be stored.

Interview with a second MA on 11/22/2021 at 9:30

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{D 079}	Continued From page 3	{D 079}		

am revealed:
-She was not aware hygiene products were stored in the unlocked wall cabinet in the common handicapped shower room.
-She was not aware of the foam hand soap on top of the towel dispenser in the common handicapped bathtub room.
-It was expected that all storage areas containing any personal hygiene care products be locked when not directly supervised by staff.
-Unlocked or unsupervised personal hygiene care products and foam hand soap increased the residents' risk of ingesting or misusing the product.

Interview with a personal care aide (PCA) on 11/22/2021 at 9:30 am revealed:
-He was not aware hygiene products were stored in the unlocked wall cabinet in the common handicapped shower room.
-He was not aware of the foam hand soap on top of the towel dispenser in the common handicapped bathtub room.
-It was expected that all storage areas containing any personal hygiene care products be stored in the locked hallway storage closet until needed by staff.
-It was the responsibility of all staff to make sure items were not easily available to the residents.

Observation of hallway A on 11/22/21 at 9:30am revealed:
-A PCA removed all personal hygiene care products from the common handicapped shower room and the foam soap from the common handicapped bathtub room.
-The products were placed in a locked hallway storage closet.

Observation of hallway A of the SCU common

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{D 079}	Continued From page 4 handicapped shower room on 11/22/21 at 4:03pm revealed: -An unsupervised male resident was exiting the shower room . -The door to the room was unlocked, cracked open and easily accessed. -A red and black metal storage wall cabinet was unlocked and partially opened. -There was one 15 ounce bottle of shampoo that was mostly full. -The shampoo bottle label included a caution to avoid contact with eyes, if contact with eyes occurs, rinse thoroughly with water. -There was one 8 ounce bottle of daily moisturizing lotion that was approximately half full. -The lotion bottle label included warning for external use only, avoid contact with eyes, in case of contact with eyes flush with water. -There was one 4 ounce bottle of body wash/shampoo that was 1/4 full. -The 4 ounce bottle of body wash/shampoo label included a warning for external use only, may cause eye irritation, and rinse eyes with water if contact occurs. Observation of hallway B of the SCU common handicapped shower room on 11/22/21 at 3:45pm revealed: -The entrance door to the common shower room was unlocked. -There was a sign posted on the backside of the door for all staff to clean up clothing, towels, and shower items when they were done with each shower. -There were residents' rooms on both side of the common bath. -On the right corner of the sink there was a 1 and 1/2 ounce stick of women's antiperspirant. -To the left of the shower, there was a wash basin	{D 079}		

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	HAL043033	A. BUILDING: _____ B. WING _____	R 11/23/2021

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ARC OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

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{D 079}	Continued From page 5	{D 079}		

that contained a comb, an open container of a ¼ full of petroleum jelly, a 1 and 1/2 ounce of women's antiperspirant, and a 15 ounce bottle of body wash.
-There was red and black metal cabinet hanging on the wall within the bathroom; the left side of the cabinet was open and not locked.
-In the unlocked metal hanging cabinet, there was an 11-oz bottle of shave foam, a bottle of antiseptic mouth rinse with 1/4 of the mouth rinse remaining, a 15 ounce bottle of body wash with 1/2 of the body wash remaining, a 12 ounce bottle of body powder with 1/2 of the body powder remaining, a bottle with no cap of whitening mouthwash with 1/4 of the mouthwash remaining, an open container of a household cleaning product containing bleach with 1/2 of the household cleaner remaining, a 12 ounce bottle of body wash with 1/4 of the body wash remaining, two disposable razors, a tube of zinc oxide with 1/2 of the zinc oxide remaining, a 2 ounce bottle of hand sanitizer with 1/2 of the hand sanitizer remaining, a 4 ounce bottle of shampoo with 3/4 of the shampoo remaining, a 1.8 ounce container of deodorant, a 12 ounce bottle of hand sanitizer with 1/2 of the hand sanitizer remaining, a 12 ounce bottle of shampoo with 1/2 of the shampoo remaining, and a 15 ounce bottle of body wash with 1/4 of the body wash remaining.

Observation of a resident without supervision who wandered on 11/22/21 at 3:45pm revealed:
-There was no facility staff in hallway B.
-The resident entered another resident's room near the common handicapped shower room and closed the door.
-At 3:50pm, the resident exited the resident's room and walked down the B hallway behind a second resident; they both entered an

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	HAL043033	A. BUILDING: _____ B. WING _____	R 11/23/2021

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

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{D 079}	Continued From page 6	{D 079}		

unoccupied resident's room near the common handicapped shower room.
-The residents closed the door to the room.
-The surveyor knocked on the door and entered the room.
-The resident was in the bathroom with the door closed and the second resident was standing at the window looking out.

Observation of a second resident without supervision who wandered on 11/22/21 at 3:50pm revealed:
-There was no facility staff in hallway B.
-The resident walked down the hallway and entered an unoccupied resident's room near the common handicapped shower room with another resident.

Interview with a personal care aide (PCA) on 11/22/21 at 3:59pm revealed:
-The residents in the SCU were not coherent enough to make the best choices.
-The residents in the SCU were known to put things in their mouth that they should not.
-The cabinets in the common handicapped shower room should be locked.
-The PCAs were responsible to ensure the cabinets were locked in the common handicapped shower room.
-The items that were stored in the common handicapped shower room cabinets were hazardous to the residents if they were to put them in their mouth.

Interview with the Resident Care Coordinator (RCC) on 11/22/21 at 4:17pm revealed:
-He was not sure if the cabinets in the common handicapped shower room were to be locked.
-He did not check the cabinets to see if any chemicals, lotions or body wash were in them.

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{D 079}	Continued From page 7 -There should not have been any chemicals, lotions or body wash in the cabinets. Interview with the Executive Director (ED) on 11/22/21 at 4:03pm revealed: -If the cabinets in the common handicapped shower room contained any chemicals they should be locked. -The PCAs and the medication aides (MA) were responsible to ensure the cabinets were locked in the common handicapped shower room . -The RCC was responsible to ensure the PCAs and the MAs kept the cabinets in the common handicapped shower room locked. -She did not know why the cabinets were unlocked in the common handicapped shower room. -There were items in the cabinets of the common handicapped shower room that could potentially harm the residents if they were to ingest them. _____ The facility failed to secure hazardous substances and items accessible to 27 residents with dementia, other cognitive impairments, and wandering behaviors residing in the SCU which placed the residents at risk for harm. Multiple bottles of shampoo and body wash, deodorant, skin moisturizers, body spray, razor blades, a cleaning product containing bleach, hand sanitizer, and hand soap were left unsecured in 3 common handicapped shower rooms. This failure was detrimental to the health, safety, and welfare of the residents who resided in the SCU and constitutes an Unabated Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation on 11/22/21.	{D 079}		

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{D 273}	Continued From page 8	{D 273}		
{D 273}	10A NCAC 13F .0902(b) Health Care	{D 273}		

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:
Based on observations, record reviews and interviews, the facility failed to ensure hospice nurse notification for 1 of 3 (#1) sampled residents related to a damaged arm rest on the resident's geriatric chair causing a skin tear wound to the resident's left elbow (Resident #1).

The findings are:

Review of Resident 1's current FL-2 dated 02/05/21 revealed:
-A diagnosis of dementia.
-The resident was non-ambulatory.
-The resident was constantly disoriented.
-The resident required total care.
-The resident was receiving hospice care.

Review of a care plan dated 02/04/21 revealed:
-The resident required a geriatric chair for transport within the facility.
-The resident was disoriented most of the time.
-The resident required extensive assistance with activities of daily living.
-The resident's skin was documented as normal.

Review of Resident #1's physician restraint orders dated 08/10/21 revealed:
-There was an order for a reclining geriatric chair with lap tray.
-The resident was to be repositioned every 2 hours and checked every 30 minutes.
-The resident was unable to participate in safety

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{D 273}	Continued From page 9 choices due to his cognitive disorder. Review of Resident #1's record on 11/22/21 revealed an alert reminder in the front of the record to contact the hospice nurse first for needs and emergencies. Observation of Resident #1's geriatric chair on 11/22/21 at 9:33 am revealed: -The left arm rest pad was loose and easily moved from side to side. -The metal arm rest frame was exposed when the padding was removed. Observation of Resident #1 on 11/22/21 at 9:35 am revealed: -The resident had a large 3x5 inch bandage on his left forearm proximal to the elbow. -The resident was not able to be interviewed. Interview with a personal care aide (PCA) on 11/22/21 at 9:35 am revealed: -The resident was found to have a skin tear to his left elbow area within the past week. -The resident's geriatric chair arm rest padding was broken and did not cover the metal frame. -The PCA reported the skin tear and the damaged chair to the medication aide (MA) working at that time. -The PCA did not remember the exact date or time. -The PCA did not remember the MA's name. Interview with a MA on 11/22/21 at 3:29 pm revealed: -The process of reporting a skin tear was for the PCA to notify the MA. -The MA was responsible to assess the skin tear, clean and bandage the skin tear, and document the information in the resident's record.	{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 _____	R 11/23/2021

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

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{D 273}	Continued From page 10 -The MA was responsible for reporting the skin tear to the Resident Care Coordinator (RCC). -The MA was responsible for notifying the hospice nurse of damaged assistive devices such as geriatric chairs. -The MA was responsible for notifying the RCC of the damaged chair and the call to the hospice nurse. -She was aware of the skin tear on Resident #1's elbow, but she did not initially treat the area. -She was not aware of the broken arm rest padding on the resident's geriatric chair. Interview with an additional MA on 11/22/21 at 3:46 pm revealed: -She was not aware of the broken arm rest on Resident #1's geriatric chair. -She did not recall when the resident's elbow was first treated for the skin tear. -The MA was to notify the resident's hospice nurse for wounds greater than a skin tear. -The resident's geriatric chair is ordered and provided through the hospice service. -The hospice nurse was scheduled to come weekly to assess the resident. Interview with the hospice nurse supervisor on 11/22/21 at 4:15 pm revealed: -The resident's hospice nurse was scheduled to visit the facility on 11/23/21. -There was no report of the resident's broken geriatric chair within the past 7 days. -The hospice service provided the geriatric chair for the resident. -The facility was responsible for notifying the hospice service of the broken chair. Interview with the RCC on 11/23/21 at 8:30 am revealed: -Equipment such as a geriatric chair was ordered	{D 273}		

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{D 273}	Continued From page 11	{D 273}		

and provided by the resident's hospice service.
-The RCC expected the damaged chair to be reported to the hospice nurse immediately.
-The process for reporting damaged equipment was the findings are reported to the MA and the MA was to report to the RCC.
-The MA was responsible for reporting the broken chair to the hospice nurse.
-He was not aware of Resident #1's broken geriatric chair.
-He expected damaged equipment to be functioning properly in order to serve the resident's needs without risking injury to the resident.
-He expected to be notified by staff of damaged equipment so he would know what the resident needs.

Interview with Resident #1's hospice nurse on 11/23/21 at 8:50 am revealed:
-She last assessed the resident on Tuesday 11/16/21.
-The resident did not have the skin tear to his left elbow area on 11/16/21.
-She had not been notified of the resident's skin tear or his broken chair.
-She expected to be notified immediately of damage to medical aide devices provided by hospice; she would have had the chair replacement ordered by now.
-She was going to notify the hospice office to order a replacement geriatric chair for the resident before exiting the facility.

Observation of Resident #1's left elbow area on 11/23/21 at 9:00 am revealed:
-An unbandaged 1.5x1.5 skin tear was near his left elbow.
-The area was scabbed and healing well with no signs or symptoms of infection.

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{D 273}	Continued From page 12 Interview with the Executive Director (ED) on 11/23/21 at 9:40 am revealed: -It was expected for all medical assistive devices like geriatric chairs to be examined for damage and cleaned every Wednesday. -It is expected that staff report damaged equipment to the RCC or ED immediately. -The damage to Resident #1's chair was not reported to her within the last week. -Hospice was responsible for providing the geriatric chairs for resident's in hospice care. -MAs were expected to notify the hospice nurse of the damaged chair. -The MAs were expected to notify the RCC when they have had to contact the hospice nurse for any reason.	{D 273}		
{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 were free from potentially harmful substances related to housekeeping and furnishings. The findings are: 1. Based on observations and interviews the facility failed to ensure the facility was free of	{D912}		

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

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{D912}	Continued From page 13 hazards in three common bathrooms where personal care hygiene products, razor blades, a cleaning product containing bleach, hand sanitizers, and hand soap were left unsecured, unattended, and accessible to 27 residents in the Special Care Unit (SCU). [Refer to Tag D0079, 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings (Unabated Type B Violation)].	{D912}		