Adult Care Home Corrective Action Report (CAR)

I. Facility Name: Cardinal Care of Dunn
Address: 217 Jonesboro Rd Dunn, NC 28334
County: Harnett
License Number: HAL-0043-034
II. Date(s) of Visit(s): 5/5/25 and 5/20/25
Purpose of Visit(s): CI 10A 10
Exit/Report Date: 5/29/25

Instructions to the Provider ***(please read carefully)*****:**

In column **III (b)** please provide a plan of correction to address *each of the rules* which were violated and cited in column **III (a)**. The plan must describe the steps the facility will take to achieve and maintain compliance. In column **III (c),** indicate a specific completion date for the plan of correction.

*If this CAR includes a **Type B violation**, failure to meet compliance after the date of correction provided by the facility could result in a civil penalty in an amount up to $400.00 for each day that the facility remains out of compliance.

*If this CAR includes a **Type A1 or an Unabated B violation**, this agency *will* plan to submit an Administrative Penalty Recommendation for the violation(s). If this CAR includes a **Type A2 violation**, this agency *may* submit an Administrative Penalty Recommendation for the violation(s). The facility has an opportunity to schedule an Informal Dispute Resolution (IDR) meeting within **15 working days** from the mailing or delivery of this CAR. If on follow-up survey the **Type A1 or Type A2** violations are not corrected, a civil penalty of up to $1000.00 for each day that the facility remains out of compliance may be assessed. If on follow-up survey the **Unabated B** violations are not corrected, a civil penalty of up to $400.00 for each day that the facility remains out of compliance may also be assessed.

III (a). Non-Compliance Identified *For each citation/violation cited, document the following four components:* • *Rule/Statute violated (rule/statute number cited)* • *Rule/Statutory Reference (text of the rule/statute cited)* • *Level of Non-compliance (Type A1, Type A2, Type B, Citation, Unabated Type A1, Unabated Type A2, Unabated Type B)* • *Findings of non-compliance*	**III (b). Facility plans to correct/prevent:** *(Each Corrective Action should be cross-referenced to the appropriate citation/violation)*	**III (c). Date plan to be completed**
Rule/Statute Number: 10A NCAC 13F .0901 (b)	☐ POC Accepted _____ *DSS Initials*	____
Rule/Statutory Reference: 10A NCAC 13F .0901 (b) (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.		
Level of Non-Compliance: TYPE A2 VIOLATION		
Findings: This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide supervision according to the needs of 1 of 5 sampled residents (#1) residing in a Special Care Unit (SCU) for a resident who had a history of wandering and exit seeking behaviors who eloped from the facility. The findings are:		

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Review of Resident #1's FL2 dated 04/09/25 revealed:
-Diagnoses included dementia with behavioral disturbance, pure hypercholesterolemia, pulmonary embolism, and gastroesophageal reflux disease.
-The resident required a SCU level of care.
-The resident was constantly disoriented.
-The resident was semi-ambulatory with a wheelchair.

Review of Resident #1's Resident Register dated 04/01/25 revealed he was admitted in April 2025 with no date listed.

Review of Resident #1's Assessment and Care Plan dated 04/09/25 revealed:
-The resident had wandering behaviors.
-The resident ambulated with an aid or device and the device needed was a wheelchair.
-The resident was disoriented sometimes, forgetful, and needed reminders.

Review of Resident #1's Admission Criteria Review dated 04/04/25 revealed:
-The resident had Alzheimer's or related dementia diagnoses.
-The resident had habitually wandered or would wander out of the building and would not be able to find the way back.
-The resident was not able to ambulate independently.
-The resident met criteria for SCU facility placement.

Review of Resident #1's monthly summary dated 04/09/25 revealed the resident ambulated with a wheelchair and was frequently hostile.

Review of Resident #1's SCU profile dated 04/17/25 revealed:
-The resident had memory impairment and no memory recall.
-The resident's decision making was poor and he required supervision.
-The resident had severe impairment and unable to make decisions.
-The resident was not able to comprehend and answer questions.
-The resident did not wander.

Review of Resident #1's monthly summary dated 05/04/25 revealed:
-The resident ambulated independently.
-The resident was confused, had poor memory, and had wandering behaviors.

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-The resident was quiet.

Review of Resident #1's incident report dated 05/04/25 revealed:
-The time of the incident was 9:13am.
-The incident was elopement without injury.
-The resident climbed out of the window and walked down the road.
-Staff completed an assessment of the resident and he was fine.

Review of Resident #1's physician's order dated 04/09/25 revealed an order for Seroquel 50mg tablet twice daily (an antipsychotic medication used to treat schizophrenia and bipolar disorder) as needed (PRN) for agitation.

Review of Resident #1's physician's order dated 04/15/25 revealed an order for Lorazepam 1mg tablet (a medication used to treat anxiety) every 6 hours PRN for agitation.

Review of Resident #1's April 2025 medication administration record (MAR) revealed:
-There was an entry for Lorazepam 1mg tablet twice daily PRN for agitation.
-Lorazepam was documented as administered 4 times for sleep or anxiety.
-There was an entry for Seroquel 50mg twice daily PRN for agitation.
-Seroquel 50mg was not documented as administered.

Review of Resident #1's May 2025 MAR revealed:
-The MAR was printed on 05/05/25.
-There was an entry for Lorazepam 1mg tablet twice daily PRN for agitation.
-Lorazepam was not documented as administered
-There was an entry for Seroquel 50mg twice daily PRN for agitation.
-Seroquel 50mg was not documented as administered.

Review of Resident #1's primary care provider (PCP) triage note dated 05/05/25 revealed:
-Staff reported the resident was exit seeking over the weekend as he was trying to leave the facility through the laundry room.
-The resident was restless and difficult to redirect.
-Staff reported the PRN medication Seroquel was effective when given.

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Review of pictures of the facility's laundry room dated 05/04/25 revealed:
-There was glass on the floor in front of the door of the laundry room.
-There was glass on the ground outside the laundry room.
-The laundry room window was not broken (it was unknown where the broken glass came from).
-The window had two glass panels on a track that opened by sliding the window to the left and one panel was pushed open completely.
-The opening was large enough for a person to climb out of.

Observation of the facility's laundry room on 05/05/25 at 9:35am revealed:
-There was a keypad lock on the laundry room door.
-The laundry room door was propped open with a chair.
-The window was partially open around 2-3 inches.
-There was glass on the ground outside of the laundry room.
-There were no staff in the laundry room or surrounding area.

Observation of the facility's security camera on 05/05/25 revealed:
-On 05/04/25 at 8:38am, Resident #1 walked down the men's hall.
-Resident #1 was wearing sweatpants and a short sleeve shirt with no socks and shoes.
-The video recording glitched and it was unable to determine which direction Resident #1 went after walking down the men's hall.

Observation of the outside premises on 05/20/25 at approximately 12:30pm revealed:
-The local gas station was .2 miles from the facility.
-There was a two-lane road with a speed limit of 45 miles per hour.
-There were no sidewalks along the road.

Interview with the Resident Care Coordinator (RCC) on 05/05/25 at 9:21am revealed:
-Resident #1 had a diagnosis of dementia with behavior disturbance.
-The Administrator called her at 9:38am (05/04/25) to let her know what happened with Resident #1 (elopement) and that he was back at the facility.

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-An employee from a local gas station called the facility at 9:13am, spoke with the medication aide (MA), and told her that a resident was there.
-A staff went and got Resident #1 from the gas station.
-She reviewed the security camera footage and Resident #1 was last seen at 8:38am.
-Resident #1 went into the laundry room and went out the window.
-Staff sent her a picture of the broken glass from the window that was on the floor in the laundry room and the ground outside.
-There was a personal care aide (PCA) on the men's hall working when Resident #1 left the facility.
-The PCA got in her car, went to the gas station to get Resident #1, and brought him back.
-Resident #1 had no injuries.
-Maintenance changed the laundry room door lock yesterday from a key lock to a keypad lock that locked automatically when closed.
-Prior to admission, she assessed Resident #1 at the hospital for admission as his previous facility would not accept him back.
-Resident #1 was pleasant in the hospital and was stable.
-Resident #1's family member told her yesterday that he was aggressive with staff at the previous facility and tried to break one of the windows at the facility.
-She denied that Resident #1 had exit seeking behaviors but stated "he walked around both halls."

Interview with a MA on 05/05/25 at 10:04am revealed:
-The PCA that was assigned to the men's hall was cleaning rooms and changing beds after breakfast (05/04/25).
-She last saw Resident #1 walking down the men's hall at an unknown time.
-Resident #1 had been walking back and forth from the men's and women's halls after breakfast.
-She assumed Resident #1 was in his room.
-The facility phone rang at 9:13am and the caller stated "I believe you are missing someone and he belongs to your facility."
-She ran around the building and made sure all the residents were present.
-She went to the laundry room, the door was open, and she noticed the window was "busted."
-She knew it was Resident #1 (refused to state how she knew) and she sent a PCA to the local gas station to get him.

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-The PCA brought Resident #1 back, she did a full assessment, the resident had no injuries, she called the Administrator and the PCP.
-Resident #1 was wearing sweatpants, a shirt, socks, and no shoes.
-The temperature outside was unknown but it started raining around 8:30am.
-She was unaware how Resident #1 broke the window and had no injuries.
-Resident #1 "was all over the place" and would go to the doors and push on them which started the fourth or fifth day after he was admitted.
-The PCA assigned to the men's hall was doing laundry on that hall.
-One of the PCAs scheduled to work at 6:00am on the men's hall called out (the facility was not short staffed) and another PCA came to work for her at 10:00am.
-Supervision of all residents was expected every 2 hours to change residents and there was always a PCA on the hall.
-PCAs were "posted" on the halls, going through rooms, and checking on the residents the entire shift.
-All staff were aware that all doors were to remain closed and locked.

Review of a local weather report dated 05/04/25 revealed:
-The weather at 8:22am was 64 degrees with light rain.
-The weather at 8:38am was 64 degrees and cloudy.
-The weather at 9:20am was 63 degrees with light rain and cloudy.

Interview with the Administrator on 05/05/25 at 10:25am revealed:
-He was on his way to the facility when the MA called him around 9:00am about Resident #1 getting out on 05/04/25.
-Resident #1 was back at the facility when the MA called.
-He arrived at the facility and did everything he was supposed to do such as complete the incident reports and he completed a training with staff on elopements.
-He denied that Resident #1 had exit seeking behaviors.
-He started 15 minutes checks on Resident #1 for 72 hours.
-All residents required supervision checks every 2 hours that included changes and ensuring they were "taken care of."
-PCAs also sat in the hallway and monitored the residents.

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-Staff discovered that Resident #1 left the facility from the laundry room window.
-The laundry room door should have been locked as he told staff all the time to lock the door.
-The key to the laundry room was kept in the medication room.
-All staff were doing laundry and he was unable to pinpoint who left the door open.
-He had an in-service with staff today after the laundry room door was left open again.

Second interview with the RCC on 05/05/25 at 10:36am revealed:
-She denied that Resident #1 was exit seeking as she had only observed him walking down the halls but never going to the doors.
-If she had known Resident #1 was "pushing on doors," she would have requested a medication change.
-Staff should have told her that Resident #1 was exit seeking and she would have put a different plan in place for him.

Interview with the laundry staff on 05/05/25 at 10:59am revealed:
-She was not working when Resident #1 eloped.
-She ensured the laundry room doors were always locked.
-She denied propping the laundry room door open today (05/05/25).
-She observed maintenance in the laundry room this morning working on the window but the door was not propped open at the time.
-She propped the laundry room door only when she was in the laundry room folding clothes.
-Resident #1 walked "up and down" the halls but she never observed Resident #1 exit seeking.
-There were two PCAs on each hall and always someone sitting in the hall watching the residents.

Telephone interview with a second PCA on 05/19/25 at 3:33pm revealed:
-She was the PCA assigned to the men's hall when Resident #1 eloped.
-Resident #1 was already up when she arrived, he ate breakfast at 7:30am in the dining room, and he did his "normal wandering" walking back and forth on the halls.
-The MA started doing laundry after breakfast on the men's hall.

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-She had not done any laundry as the MA finished the laundry that was not finished on third shift.
-A PCA that was assigned to the men's hall with her called out, there were two PCAs assigned to the women's hall, one of them helped her, and worked both halls.
-She was on the men's hall making beds between 9:00-9:30am and she heard the MA state a lady from the store called and said a resident got out.
-She could not recall what time she last saw Resident #1 on 05/04/25 but stated he was on the men's hall near the back door.
-She got into her vehicle and headed towards interstate 95, she saw Resident #1 walking on the left side of the gas station, she stopped him, and got him in the car.
-It was raining, Resident #1 was wet, had no shoes on, and his feet were muddy.
-Resident #1 was a wanderer and had exit seeking behaviors since the second week he was admitted, he walked down the halls, and would push on the doors at the end of the hallway.
-She told the MA about Resident #1's exit seeking behaviors and he was administered an as needed medication for his behaviors.
-All residents were supervised every 2 hours including Resident #1.
-None of the facility door alarms sounded so she assumed Resident #1 left the facility from the laundry room window.

Telephone interview with a third PCA on 05/19/25 at 4:10pm revealed:
-She was working on the women's hall when Resident #1 eloped.
-She last saw Resident #1 in the dayroom before he left but the time was unknown.

Telephone interview with the cook on 05/19/25 at 4:16pm revealed:
-He was working in the kitchen the day Resident #1 eloped.
-He observed Resident #1 in the dining hall during breakfast at 7:30am, breakfast typically ended around 8:15am-8:20am, and he did not see him again after breakfast.
-He saw Resident #1 when he returned and he had no injuries.
-Resident #1 was a wanderer and he observed him going to doors and tapping on the doors to try to get out.
-He did not tell management about his observations of Resident #1's exit seeking behaviors as he believed he had calmed down and no longer was "pushing on doors."

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Telephone interview with the RCC on 05/21/25 at 9:54am revealed according to the facility's video footage Resident #1 was last seen at the facility at 8:37am and a PCA returned with him at 9:28am.

Telephone interview with Resident #1's psychiatric nurse practitioner on 05/21/25 at 2:29pm revealed:
-She saw Resident #1 once on 04/10/25 for the initial psychiatry consult, he was very confused and could not answer questions.
-Resident #1 was being treated for unspecified dementia with anxiety.
-Staff did not report that he was exit seeking during the initial consult.
-She ordered medications for Resident #1 on 04/10/25 that included Lorazepam and Seroquel for agitation and anxiety.
-Staff called her about Resident #1's exit seeking on 05/04/25, she was unavailable; therefore, her supervisor met with him via telehealth on 05/05/25.
-Her supervisor ordered Seroquel as a scheduled medication due to the resident exit seeking and staff being unable to redirect him.
-She was not aware that Resident #1 left the facility unsupervised.
-Resident #1 was very confused and it was not a good idea for Resident #1 to have no supervision.

Second telephone interview with the RCC on 05/27/25 at 9:54am revealed:
-Resident #1's PRN medications for anxiety could be used for exit seeking behaviors.
-The MAs should have given Resident #1 a PRN medication if he was observed agitated and exit seeking.

Telephone interview with Resident #1's PCP on 05/22/25 at 4:33pm revealed:
-The facility staff called him and stated that the resident tried to get out of the facility a couple of weeks ago.
-He referred the resident to psychiatry to see if any medications needed to be increased.
-He was not aware that the resident left the facility unsupervised.
-He could not recall if staff reported that Resident #1 had exit seeking behaviors.
-Resident #1 had dementia, was oriented to self only, and was confused.

Facility Name:

(Continued from page 9) -Resident #1 leaving the facility unsupervised was a risk and with his cognition he would not realize where he was going and would wander. Attempted telephone interview with Resident #1's family member on 05/21/25 at 9:33am was unsuccessful. --- The facility failed to supervise a resident who resided in a SCU, had dementia with wandering and exit seeking behaviors, who eloped from the facility in the rain at 64 degrees with no shoes or socks. This failure resulted in substantial risk of serious physical harm to Resident #1 and constitutes a Type A2 Violation. --- The facility provided a Plan of Protection in accordance with G.S.131D-34 on 05/05/25. THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 28, 2025.		

IV. Delivered Via:	Electronic mail (email)	Date: 05/29/25
DSS Signature:	Angel Tinley, AHS	Return to DSS By: 6/20/25

V. CAR Received by:	Administrator/Designee (print name): Cedric Brundidge	
	Signature: Cedric Brundidge	Date: 5/29/25
	Title: Administrator	

VI. Plan of Correction Submitted by:	Administrator (print name):	
	Signature:	Date:

VII. Agency's Review of Facility's Plan of Correction (POC)		
☐ ***POC Not Accepted***	By:	Date:
Comments:		

Facility Name:

☐ ***POC Accepted***	By:	Date:
Comments:		

VIII. Agency's Follow-Up	By:		Date:
	Facility in Compliance: ☐ Yes ☐ No		Date Sent to ACLS:
Comments:			
**For follow-up to CAR, attach Monitoring Report showing facility in compliance.*			