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	HAL063011	A. BUILDING: _____ B. WING _____	R 08/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TARA PLANTATION OF CARTHAGE	820 S. MCNEILL STREET CARTHAGE, NC 28327

(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 Moore County Department of Social Services conducted a follow-up survey on August 8-10, 2018.	{D 000}		
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: Based on interviews and record reviews, the facility failed to notify the medical provider for 2 of 5 sampled residents (#4, #5) for observed behaviors that included two incidences of a female resident being touched inappropriately and verbal aggressive behaviors toward staff (#5); and failed to follow up with a medical provider after a resident who was unable to provide consent due to severe cognitive impairment was touched twice inappropriately by another resident (#4). The findings are: 1. Review of Resident #5's current FL-2 dated 06/20/18 revealed: -Diagnoses included dementia, history of cerebrovascular accident, history of alcohol abuse, and hypertension. -Resident #5 was intermittently disoriented and wandered. -Resident #5's level of care was documented as a special care unit (SCU). -There was an order for Depakote 125mg (a	D 273		

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D 273	Continued From page 1 medication used to treat mood disorders) daily. Review of Resident #5's previous hospital generated FL-2 dated 06/05/18 revealed an order for Depakote 125mg daily. Review of Resident #5's Resident Register revealed: -There was an admission date of 06/05/18. -The resident's former address was from another assisted living facility (named). -There was documentation in the Discharge/Transfer Information section which included a notice of discharge/transfer to a local medical center on 06/29/18, initiated by the Administrator due to a past history of inappropriate behavior. Review of Resident #5's Discharge summary from a local hospital revealed: -The resident was admitted on 05/25/18 and discharged 06/05/18. -The residents diagnoses included dementia and the discharge condition was "stable, improved". -The resident was previously living at another assisted living facility (named). -The details of the event were unclear but apparently the resident got into an altercation with a resident and/or staff member. -The resident was sent to the emergency department due to agitation originally on 05/11/18. -He was given two doses of Geodon (an antipsychotic medication used to treat schizophrenia and bipolar disorders) in the emergency room with improvement in agitation. -The resident stayed in the emergency department for a couple of weeks while case management sought placement, however, there were several obstacles.	D 273		

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D 273	Continued From page 2 -The resident was admitted on 05/25/18 to hospitalist services to transition the resident out of the emergency department for better patient care. -It took a while to find placement but the resident finally was accepted by a facility. Review of Resident #5's Assessment and Care plan dated 06/25/18 revealed: -The resident was sometimes disoriented, was forgetful and needed reminders. -There was documentation in the social and mental health history that included staff should observe the resident to make sure the resident did not display any inappropriate behavior. Review of Resident Occurrence records for Resident #5 revealed: -There was a handwritten entry on 06/11/18, with documentation over the weekend there was possible inappropriate touching of another resident. -Staff would continue to monitor that this would not take place again. -There was a second handwritten entry on 06/11/18 with documentation Resident #5 sat down beside a resident and kissed her, placing his hand near "her private". Resident #5 asked the female resident did that feel good. -On 06/14/18 there was a handwritten entry Resident #5 was trying to get a "lady resident" to come in his room. Staff told Resident #5 he could not get "lady residents" in his room. -On 06/24/28, there was documentation to keep an eye on Resident #5, he was trying to be sneaky. -On 06/26/18, there was a handwritten entry with documentation that included continuously telling Resident #5 not to touch the lady residents in any way.	D 273		

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D 273	Continued From page 3 Review of a form labeled "Report of Health Services to Residents Physician's Orders" for Resident #5 revealed: -There was a computer printed entry, "can we have an order for Psychiatry Services", "Please circle one". -There were eleven numbered computer printed entries that gave a brief description for the reason for psychiatry services. There was handwritten circle around "1.", "Adjustment to placement in facility". -Reduction of inappropriate sexual behaviors and reduction of conflictual relationships were listed but not circled as the reason for psychiatry services. -The primary care provider (PCP) signature was not dated. Review of a mental health provider (MHP) visit note for Resident #5 dated 06/28/18 revealed: -The type of visit was documented as a follow-up evaluation and the reason for the follow-up visit was per the PCP and staff request. -Adjustment to facility placement was documented as the chief complaint. -In the History of Present Illness section there was documentation that included the resident was seen today, (06/28/18) for psychiatric evaluation. The resident had a history of dementia, sexually inappropriate behavior, aggression and impulsivity and was last seen by the same mental health provider agency on 03/13/18 while living at another facility. Records showed that he was previously discharged from another facility due to increased risk to other residents' safety because of continued aggression and inappropriate sexual behavior. The resident had multiple episodes where he was found to be with female resident inappropriately in	D 273		

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a sexual manner with one incident of Resident #5 receiving oral sex from another female resident. "Resident" that he was found with are unable to provide consent due to advanced dementia. The resident had a significant history of aggression including physical altercations with other male residents and became agitated when redirected. The resident was investigated at the last facility for physically assaulting a female resident. Recommendation from the last mental health provider in March was to find alternative placement for the resident due to continued risk of harm to other residents.
-Today (06/28/18), staff had reported he had been sexually inappropriate with two female residents and staff. The resident was observed touching female residents inappropriately and had been verbally aggressive towards staff. The resident denied being sexually inappropriate on exam, there were no overt signs and symptoms of delusions or mania. Depakote would be increased to manage the resident's impulsivity.
-There was an order in the recommendations section of the visit note to increase Depakote 125mg to three times daily for mood disorders.

Interview with a medication aide (MA) on 08/09/18 at 9:40 a.m. revealed:
-She had observed an incident with Resident #5 in June 2018.
-She and another staff (named) observed Resident #5 walking towards Resident #4 while Resident #4 was playing the piano in the SCU.
-Resident #5 would look back at the MA and the other staff while he was walking toward Resident #4 which made both staff "suspicious".
-Both she and the other staff continued to observe Resident #5 and moved themselves so that Resident #5 could not see them watching. Resident #5 continued to look back toward them

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and when he thought they could no longer see him, Resident #5 placed his hand on Resident #4's breast.
-She and the other staff immediately walked over to the residents and removed Resident #4 away from Resident #5.
-She told Resident #5 not to touch female residents at all or any other residents.
-She reported the incident to the oncoming MA for the next shift who told staff on the next shift.
-She never documented the incident but knew she should have.
-She thought the incident occurred the day before Resident #5 kissed Resident #4 (the incident that was documented on 06/11/18).
-She had also observed a second incident involving Resident #5 approaching a female resident (named) and Resident #5 rubbed the resident's hair and she thought that was "creepy".
-She and other staff would hide behind the beam columns in the SCU to observe Resident #5 because he would always look around first to see if staff where watching him.
-Resident #5 would curse at staff.
-She was not sure but thought Resident #5's MHP was notified regarding the resident's aggressive behaviors toward staff but did not know if the resident's MHP was contacted about the observed behaviors with the female residents but she did not contact the MHP or PCP.

Interview with a housekeeper on 08/09/18 at 10:14 a.m. revealed:
-She and another staff had observed the incident that occurred on 06/11/18 when Resident #5 kissed Resident #4 in the mouth then touched her on the inner part of her upper thigh and asked her if that felt good.
-They stopped Resident #5 and he walked away.
-The incident was reported to the Administrator

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but she did not know if the incident was reported to the resident's PCP.
-Resident #5 would also "curse out" staff at times.

Interview with the laundry person on 08/09/18 at 3:10 p.m. revealed:
-Resident #5 gave her the "Heebie-jeebies" because of the way he was with some of the residents (she could not give any additional information).
-She had to "always" chase him away from Resident #5.
-She had observed him in Resident #4's room playing with her baby dolls.
-She had never seen Resident #5 place his hands on Resident #4 but had heard staff talking about him making "advancements on her" and had touched and kissed her.

Attempted telephone interview with Resident #5's family member on 08/09/18 at 8:07 p.m. at was unsuccessful.

Interview with the Administrator on 08/09/18 at 10:55 a.m. revealed:
-Someone said there were two incidences of Resident #5 touching Resident #4, however, she was under the impression there was only one incident. She was aware of the incident on 06/11/18 when Resident #5 kissed and placed his hand on Resident #4's leg.
-Resident #4 was the only other resident Resident #5 seemed to be drawn to and she thought he might have mistaken Resident #4 for someone else in his past.
-A referral was made to Resident #5's MHP because of Resident #5 touching female residents.
-The MHP made visits to the facility every other week.

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-The facility stepped up Resident #5's monitoring and supervision to keep a constant eye on him and redirect him after the incident on 06/11/18.
-The facility was not aware of Resident #5's behavior history when he was admitted to the facility.
-When the MHP saw Resident #5, the MHP contacted the facility on 06/28/18 and that was when they found out about his behavior history and the MHP recommended an immediate discharge. She then immediately contacted the Department of Social Services for "technical support".
-One on one staff supervision was provided after speaking with the MHP on 06/28/18 until the resident was sent out to an inpatient hospital on 06/29/18.
-The Special Care Unit Coordinator (SCUC) should have documented the date and time Resident #5's MHP was contacted regarding his behaviors.
-She would see if she could locate the documentation when Resident #5's MHP was contacted.

Interview with the SCUC on 08/10/18 at 2:00 p.m. revealed she was on vacation from 06/11/18 through 06/18/18 and was not sure if contact was made with Resident #5's MHP or PCP regarding his behaviors.

Telephone interview with the MHP on 08/09/18 at 5:25 p.m. revealed:
-She made visits to the facility every 2 weeks.
-Prior to her visit on 06/28/18, she did not receive any notification regarding Resident #5's behaviors but would have expected the facility to contact her as an urgent need for a referral visit regarding Resident #5's behaviors.
-If she could not have seen Resident #5 she

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could have consulted with his PCP regarding treatment until she could have evaluated him.
-If there was an urgent need for a resident to be seen then she expected the facility to contact her.

Telephone interview with Resident #5's PCP on 08/10/18 at 2:05 p.m. revealed:
-She had seen the resident at the facility she thought twice and none of the behaviors had occurred yet when she had seen the resident.
-She was first contacted by telephone the last of June 2018 (could not remember exact date and she did not have access to her documentation) by a social worker from the local Department of Social Services followed by a phone call from the facility regarding Resident #5's behaviors and past behavior history.

2. Review of Resident #4's FL-2 dated 7/06/2018 revealed:
-Diagnoses included dementia, borderline hypertension, vitamin D deficiency and vitamin B deficiency.
-The resident was constantly disoriented and wandered.

Review of Resident #4's Resident Register revealed the resident was admitted to the facility on 5/25/2017.

Review of Resident #4's Care Plan dated 6/21/2017 revealed:
-The resident had a significant memory loss and must be directed.
-The resident required assistance or supervision with all activities of daily living (ADL).

Review of an Incident/Accident Report dated 6/29/18 revealed:
-On 6/11/18 staff reported Resident #5 exhibited

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some inappropriate behavior with a female resident. Female resident was removed from the area and Resident #5 was redirected.
-The special care unit coordinator prepared the incident report.
Review of the facility's "Residents Occurrence Record" revealed there were no documentation of any occurrences between 6/6/18 to 7/7/18.

Interview with Resident #4's family member on 08/08/18 at 5:50pm revealed:
-The facility did not inform the family of an incident between Resident #4 and Resident #5 until sometime in July 2018 (not sure of the date) after the local department of social services (DSS) had called and discussed the incident.
-The facility informed the family member that Resident #5 had touched Resident #4's breast but she was ok.
-The facility did not give the date of the incident and only reported one incident.
-The SCUC informed the family member Resident #5 had been discharged from the facility.

Interview with a medication aide (MA) on 08/09/18 at 9:40 a.m. revealed:
-She had observed an incident involving Resident #4 and Resident #5 in June 2018.
-She and another staff observed Resident #5 walking towards Resident #4 while Resident #4 was playing the piano in the special care unit (SCU).
-Resident #5 looked back at the MA and the other staff while he was walking toward Resident #4.
-Both she and the other staff continued to observe Resident #5 and moved themselves so that Resident #5 could not see them watching. Resident #5 continued to look back toward them and when he thought they could no longer see

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him, Resident #5 placed his hand on Resident #4's breast (on top of her clothes).
-The MA and the other staff immediately walked over to the residents and removed Resident #4 away from Resident #5.
-She reported the incident to the oncoming MA for the next shift who told staff on the next shift.
-She never documented the incident but knew she should have.
-She thought the incident occurred the day before Resident #5 kissed Resident #4 (the incident that was documented on 06/11/18).
-The incident was reported to the SCUC, but she did not know if the incident was reported to Resident #4's primary care provider (PCP).

Interview with a housekeeper on 08/09/18 at 10:14 a.m. revealed:
-She and another staff had observed the incident that occurred on 06/11/18 when Resident #5 kissed Resident #4 in the mouth then touched her on the inner part of her upper thigh and asked her if that felt good.
-They stopped Resident #5 and he walked away.
-The incident was reported to the Administrator but she did not know if the incident was reported to the resident's PCP.
-Resident #5 would also "curse out" staff at times.

Interview with a personal care aide (PCA) on 08/10/18 at 10:25am revealed:
-She had worked in the SCU since May 2018 and her working hours were from 7:00am until 7:00pm.
-Resident #4 was confused at all times, unable to answer simple questions, and wandered through out the SCU, including other residents' rooms.
-Resident #4 was incontinent of bowel and

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bladder and required 2 staff to complete incontinent care and total assistance with baths.
-On 6/11/2018, (late morning) Resident #4 was sitting on the couch in the commons area watching TV.
-The PCA and the housekeeper was standing at the janitor's closet which was approximately 100 feet from the back of the couch.
-Resident #5 walked out of his room and approached the couch. The resident leaned over and kissed Resident #5 on her mouth.
-Resident #5 then sat down close to Resident #4.
-The PCA and the housekeeper approached the couch and observed Resident #4 with his hand between Resident #5's legs and he was rubbing her very close to her vagina and asking her if this "feels good".
-The resident was wearing adult briefs and a dress. She did not know whether he had his hand inside the brief.
-The PCA assisted Resident #4 off the couch and she walked away. Resident #4 walked away toward his room.
-The PCA and the housekeeper reported the incident to the Administrator immediately and reported the incident to the MA. The MA was no longer working at the facility.

Interview with the Administrator on 08/09/18 at 10:55am revealed:
-The SCUC and the MAs were responsible for reporting incidents to the health care providers.
-Resident #4's primary health care provider made visits to the facility 2 times a week and had access to the resident's record.
-She did not know if the resident's PCP was aware of the incident involving Resident #4.
-If a resident from the assisted living unit had gone to the SCU and touched a resident

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inappropriately, this would be different and would need to be reported. But since both residents were on the SCU and both had dementia, the incidents were not reportable because this kind of behavior (sexual behavior) was expected to occur.

Interview with Resident #4's PCP on 08/10/18 at 11:20am revealed:
-The PCP and another medical provider from the same practice made medical visits to the facility two times a week.
-The facility had never reported any incidents involving Resident #5 touching Resident #4's breasts, inner thighs or kissing her on her mouth.
-The PCP expected the facility to report these incidents.
-If the PCP was aware of these incidents, she would have recommended/ordered the residentto be sent to the emergency department for evaluation for injuries/rape, or she would have assessed the resident for injuries including bruising, scratches swelling on breasts, vaginal area and mouth.
-Resident #4 was not able to give consent for sexual activity based on the progression of her advanced dementia. She was unable to understand or answer questions or follow directions.

Interview with another medical provider on 8/10/18 at 2:00pm revealed:
-The medical provider worked at the same medical practice as Resident #4's PCP.
-The medical provider was informed of incident which occurred between Resident #5 and #4 by a social worker (SW) from the local department of social services in July 2018.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TARA PLANTATION OF CARTHAGE	820 S. MCNEILL STREET CARTHAGE, NC 28327

(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 13 -The SCUC informed the medical provider of the incident after the SW had told her. -The medical provider was not aware there were 2 separate incidents, she was not aware Resident #5 and been caught kissing the resident on her mouth, or had his hands on her inner thighs near her genital area. -Resident #4 was not able to give consent for intimate contact with anyone because she had advanced dementia. The resident walked around the SCU hugging a doll baby and did not understand it was not a real baby. -Resident #4 may need to a follow-up with a gynecologist to rule out any problems for the two incidents. Interview with the SCUC on 08/10/18 at 2:00 p.m. revealed she was on vacation from 06/11/18 through 06/18/18 and was not sure if contact was made with Resident #4's PCP regarding both incidents that involved Resident #5.	D 273		