STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063011	A. BUILDING: _____ B. WING _____	R 02/10/2026

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 Moore County Department of Social Services conducted an annual and follow-up survey and a complaint investigation on February 9, 2026, through February 10, 2026.	D 000		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to notify the local county Department of Social Services (DSS) within 48 hours of incidents for 3 of 6 sampled residents who had a fall with an injury (#6) and a resident who had 3 falls resulting in injuries (#1), all of which required medical intervention greater than first aid at a local emergency department. The findings are: Review of Accident/Incident/Fall Policy dated February 2019 revealed: -When an incident or accident occurred, the staff did the following: Complete an incident report, report appropriately	D 451	Administrator met with facility Manager and Care Coordinators. The following was implemented: 1) The Care Coordinators will check with MA daily to ensure that reports are being completed if necessary. 2) The Care Coordinators will fax the report to DSS and ensure all other notifications have been made. 3) The Care Coordinators will fax to DSS and ensure fax receipt or document date, time, and initial. 4) Report will be given to the facility Manager for filing in the Accident/Incident report binder.	3/9/2026

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Kathy Huffman, Administrator — (X6) DATE: 3/9/2026

Reviewed & Acknowledged SC 3/17/26

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D 451	Continued From page 1	D 451		

(DSS, Administrator, Physician, Responsible Party, Etc.), implement behavior tracking tool (attached), document in resident occurrence book, and refer to employee policy on abuse, neglect and misappropriation of resident property.
-When an incident or accident occurs when a resident falls, the staff should do the following: Complete an incident report, contact physician for your information , contact family, implement behavior tracking tool, in the meantime, Care Coordinator will do an overall assessment: review medications (changes), general health (changes), diet (changes, change in food intake), environmental changes. (Fall-risk Assessment Form), if a resident falls 3 (three) times within one month, a request for physical therapy (PT) and occupational therapy (OT) evaluation will be sent to physician, a care planning meeting will be scheduled, Care Coordinator will document overall assessment and care planning in the resident occurrence following the care planning meeting, and if falls do not reduce, possible upgrade will be considered.

1. Review of Resident #6's current FL2 dated 11/05/25 revealed:
-Diagnoses included dementia, hypertension, delusional behaviors, acute renal failure, and major depressive disorder.
-Resident #6 was constantly disoriented.
-Resident #6 required assistance with bathing and dressing.
-Resident #6 was ambulatory.

Review of Resident #6's Resident Register revealed an admission date of 11/02/18.

Review of Resident #6's emergency department (ED) after visit summary (AVS) dated 09/26/25 revealed:

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D 451	Continued From page 2	D 451		

-Resident #6's reason for visit was left wrist pain.
-Resident #6's diagnosis was left wrist pain.
-Resident #6 had an imaging that consisted of an x-ray.
-A wrist splint was placed on the left hand.
-A referral was made to orthopedic surgery.
-Resident #6 was discharged back to the facility.

Review of Resident #6's accident/incident (A/I) report revealed:
-An unknown accident/incident occurred on 09/26/25 at 6:57pm.
-Resident #6 complained of pain in left wrist.
-The word "faxed" was stamped on the A/I report but did not say to where or whom the A/I was faxed.
-The emergency department and the guardian were notified.
-The A/I report did not make any reference of notification to the local county Department of Social Services (DSS) Adult Home Specialist (AHS).

Review of Resident #6's hospice progress notes dated 09/30/25 revealed:
-Resident #6 had a scaphoid fracture of thumb.
-Resident #6 would be placed in a cast for three weeks, returned for cast removal and x-ray of thumb sprain.

Interview with the medication aide (MA) on 02/10/26 at 10:00am revealed:
-Resident #6 had an unwitnessed fall at the end of September 2025 but could not recall the exact date.
-Resident #6 was found during evening rounds around 5:30pm and her wrist was hot to touch.
-The last time Resident #6 was checked was around dinner at 4:30pm on 09/26/25.
-She sent Resident #6 immediately out to the

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D 451	Continued From page 3	D 451		

hospital.
-She completed an A/I report for Resident #6 and gave it to the Administrator.

Interview with the Administrator on 02/10/26 at 5:12pm revealed:
-She faxed the A/I report to the guardian.
-She faxed the A/I report to the local DSS Adult Home Specialist (AHS) but did not have the confirmation to review.
-She usually waited for the confirmation but did not that day because a lot was going on that day.

Interview with the local DSS Adult Home Specialist (AHS) on 02/10/26 at 4:20pm revealed she had not received an incident report for Resident #6's fall on 09/26/25.

Based on observations, interviews and record reviews, it was determined Resident #6 was not interviewable.

Refer to the interview with medication aide (MA) on 02/10/26 at 10:00am.

Refer to the interview with the Adult Home Specialist (AHS) on 02/09/26 at 1:30pm.

Refer to the interview with the Resident Care Coordinator (RCC) on 02/10/26 at 4:10pm.

Refer to the interviews with the Administrator on 02/09/26 at 1:44pm and on 02/10/26 at 4:15pm.

2. Resident #1's current FL2 dated 09/30/25 revealed diagnoses including second degree burn, diabetes mellitus, hyperlipidemia, hypertension, myocardial infarction, stroke, major depressive disorder, back pain, coronary artery disease, and history of fusion of cervical spine.

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D 451	Continued From page 4 Review of Resident #1's Resident Register revealed Resident #1 was admitted to the facility on 09/26/24. Interview with Resident #1 on 02/10/26 at 11:00am revealed: -He used a rolling walker for a while to help with walking until he had a few falls using it. -He used a wheelchair now. -He had fallen once a few weeks ago when he was using his walker; he tripped over the walker. -He had another fall when he had been sitting for a while and he thought his legs might have gone to sleep and when he got up his legs went out from under him cause he could not feel them. -He went out to the hospital and had x-rays done but they were all okay except he had a broken rib from one of the falls. -The facility provider had seen him after his falls to follow up with what the hospital had said. -He had lidocaine patches ordered for the pain on his right side from the broken rib and they helped. Interview with personal care assistant (PCA) on 02/10/26 at 11:45am revealed: -Resident #1 had fallen a couple of times that she knew of in the last month or so. -He had been using a rolling walker before those falls but now he used his wheelchair. -She was not sure of any injuries other than some scrapes and bruises but he had been out to the emergency room when he fell. Interview with medication aide (MA) on 02/10/26 at 10:00am revealed: -When a resident has an incident or accident (I/A) the PCA would let the MA know and the MA would assess the resident and determine if the resident needed just first aid for like a skin tear or if they	D 451		

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D 451	Continued From page 5	D 451		

need to be sent out to the emergency department (ED) for further care.
-The MA completed the I/A report and gave it to the Administrator; if she was out of the facility, the MA would slide the report under her door.
-She was not sure who would send the report to the county Department of Social Services (DSS).
-Resident #1 had fallen 3 times that she remembered in January 2026, and he had been sent out for at least 2 of the 3.
-She thought he had refused one time to go out but the PCP had ordered x-rays to make sure he was okay and ordered physical therapy to evaluate him.
-He used his wheelchair now and not his rolling walker since he had fallen.

Review of Resident #1's record revealed:
-There was no Accident and Incident report dated 01/15/26.
-There was no documentation the local county Department of Social Services (DSS) had been notified of Resident #1's injury on 01/15/26.

Review of Resident #1's record revealed:
-There was no Accident and Incident report dated 01/30/26.
-There was no documentation the local county DSS had been notified of Resident #1's injury on 01/30/26.

Interview with the Resident Care Coordinator (RCC) on 02/10/26 at 4:10pm revealed:
-When an accident or incident occurred that required more than just a band aid, an Incident/Accident (I/A) report should be completed.
-Unwitnessed falls, head injury, or bleeding (more than a band aid), would require an I/A report to be completed.

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D 451	Continued From page 6	D 451		

-The MA was responsible for completing the I/A report and gave it to the Administrator; if the Administrator was not in the facility at the time of the incident, the MA would place the report under her office door.
-The Administrator was responsible for faxing the report to the county's Department of Social Services.
-She was aware of 3-4 falls that Resident #1 had in the past month (January 2026) but could not recall the exact dates.
-She was not aware that the 3 falls had not had an I/A report completed.
-Resident #1 had problems with his feet and legs "going to sleep" and then he would try to stand up and walk before the feeling and sensations returned which caused him to stumble and fall.

Interview with the Administrator on 02/10/26 at 4:15pm revealed:
-When an incident or accident occurred, PCA would let the supervisor/MA know.
-The MA assessed the resident and let the RCC or Special Care Unit Coordinator (SCC) know of the I/A.
-The MA, RCC, or SCC would call Emergency Medical Services (EMS) if the resident needed transport to the local emergency department (ED).
-The Primary Care Provider (PCP) would be notified of the fall.
-The MA, RCC, or SCC would notify the resident's family, responsible person, or guardian.
-The MA would complete the I/A reports for anything that required more that first aide, if the resident had to be sent out to the ED.
-The MA would give the I/A report to her.
-She had not faxed the I/A reports to the county DSS as the Administrator.
-She thought Resident #1 had 2 or 3 falls within

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D 451	Continued From page 7 the past month, but she was not sure of the exact number. -Resident #1 had some x-rays done and had some bruising and skin abrasions resulting from his falls. -The bruising on Resident #1's side was from a rib fracture, and the PCP had followed up with visits after each of his falls. -The PCP had ordered physical therapy (PT) evaluation to be done due to his falls. Refer to the interview with the Adult Home Specialist (AHS) on 02/09/26 at 1:30pm. Refer to the interview with the Administrator on 02/09/26 at 1:44pm. _____ Interview with medication aide (MA) on 02/10/26 at 10:00am revealed: -When a resident had an incident or accident (I/A) the personal care aide (PCA) would let the MA know and the MA will assess the resident and determine if the resident needs just first aid for like a skin tear or if they need to be sent out to the ED for further care. -The MA completed the I/A report and gives it to the Administrator; if she was out of the facility, the MA would slide the report under her door. -She was not sure who would send the report to the county Department of Social Services (DSS). Interview with the local DSS Adult Home Specialist (AHS) on 02/09/26 at 1:30pm revealed: -She received A/I reports from facilities via fax or email. -She checked her emails and checked with her supervisor to ensure there were none received from the facility fax. -She had not received any A/I reports from the facility.	D 451		

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D 451	Continued From page 8 Interview with the Resident Care Coordinator (RCC) on 02/10/26 at 4:10pm revealed: -When an accident or incident occurred that required more than just a band aid, an Incident/Accident (I/A) report should be completed. -Unwitnessed falls, head injury, or bleeding, would require an I/A report to be completed. -The MA was responsible for completing the I/A report and gave it to the Administrator; if the Administrator was not in the facility at the time of the incident, the MA would place the report under her office door. -The Administrator was responsible for faxing the report to the county's DSS. Interview with the Administrator on 02/09/26 at 1:44pm revealed: -All reportable and non-reportable incident and accident reports were required to be completed. -If an incident or accident was reportable to the department of social services (DSS) it was required to be sent within 24 to 48 hours of the incident or accident. -An incident or accident report was required to be sent to the DSS if more than first aide was required. -If a resident went to the hospital and returned to the facility the same day it did not need to be reported to the DSS. -An incident or accident had to be reported to the DSS if the resident was admitted to the hospital, needed treatment that could not have been provided at the facility, or surgery. -The Administrator usually sent the incident or accident report to the DSS but the RCC also sent them at times. Second interview with the Administrator on	D 451		

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D 451	Continued From page 9 02/10/26 at 4:15pm revealed: -When an incident or accident occurred, the PCA would let the supervisor/MA know. -The MA assessed the resident and let the RCC or Special Care Unit Coordinator (SCC) know of the I/A. -The MA, RCC, or SCC would call Emergency Medical Services (EMS) if the resident needed transport to the local emergency department (ED). -The resident's Primary Care Provider (PCP) would be notified. -The MA, RCC, or SCC would notify the resident's family, responsible person, or guardian. -The medication aides would complete the I/A reports for anything that required more that first aide, if the resident had to be sent out to the ED. -The MA would give the I/A report to her. -She had not faxed the I/A reports to the county DSS as the Administrator.	D 451		