STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL045005	A. BUILDING: _____ B. WING _____	R 01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCULLOUGH'S REST HOME	720 ORR'S CAMP ROAD HENDERSONVILLE, NC 28739

(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 an annual and follow up survey and a complaint investigation on 01/14/26 and 01/16/26.	D 000		
D 139	10A NCAC 13F .0407(a)(7) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (7) have a criminal background check completed in accordance with G.S. 131D-40 and results available in the staff person's personnel file; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled staff (Staff C) had a criminal background check prior to hire. The findings are: Review of Staff C's, (Housekeeper), personnel record revealed there was no documentation of a criminal background check completed prior to hire. Interview with Staff C on 01/14/26 at 1:59pm revealed: -She was a part time employee. -She did not remember signing a consent for a criminal background check. -She did not know if the facility conducted a criminal background check. Interview with the Administrator on 01/16/26 at 8:45am revealed: -She hired Staff C on 01/05/26. -She knew staff had to have a criminal background check.	D 139		

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D 139	Continued From page 1 -Staff C performed housekeeping duties and did not provide resident care. -She didn't have a chance to get to the Clerk of Courts to get a Criminal Background Check on Staff C. -She will get a criminal background check "next week".	D 139		
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 A2 VIOLATION Based on interviews and record reviews, the facility failed to notify the primary care provider for 1 of 3 sampled residents, (#2), related to elevated finger stick blood sugar readings. The findings are: Review of Resident #2's current FL2 dated 05/22/25 revealed diagnoses included diabetes (a chronic disease that occurs when blood glucose levels are too high) and diabetic neuropathy (nerve damage caused by diabetes). Review of Resident #2's Resident Register revealed an admission date of 02/08/24. Review of Resident #2's physician's orders dated 12/03/25 revealed: -Check finger stick blood sugar (FSBS) before every meal and at bedtime.	D 273		

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D 273	Continued From page 2 -Call the Primary Care Provider (PCP) for FSBS readings > 300. Review of Resident #2's medication administration record (MAR) for December 2025 revealed: -There was an entry to obtain FSBS readings at every meal and at bedtime. -There was documentation at 7:30am of FSBS readings were greater than 300 on 12/01/25 = 474, 12/03/25 = 411, 12/13/25 = 520, 12/19/25 = 441, 12/20/25 = 509, and 12/30/25 = 426. -There was documentation at 11:30am of FSBS readings were greater than 300 on 12/02/25 = 372, 12/13/25 = 382, 12/17/25 = 389, 12/19/25 = 455, and 12/21/25 = 321. -There was documentation at 4:30pm of FSBS readings were greater than on 12/01/25 = 412, 12/03/25 = 312, 12/04/25 = 342, 12/08/25 = 462, 12/13/25 = 509, 12/17/25 = 591, 12/18/25 = 498, 12/19/25 = 450, 12/20/25 = 489, 12/21/25 = 458, and 12/22/25 = 574. -There was no documentation that FSBS checks were obtained at bedtime. -There was no documentation Resident #2's PCP was notified of FSBS >300 from 12/01/25 - 12/31/25. Review of Resident #2's MAR for 01/01/26 - 01/13/26 revealed: -There was an entry to obtain FSBS readings at every meal and at bedtime. -There was documentation at 7:30am of FSBS readings were greater than 300 on 01/04/26 = 497 and 01/12/26 = 325. -There was documentation at 11:30am of FSBS readings were greater than 300 on 01/05/26 = 368, 01/06/26 = 425, and 01/09/26 = 457. -There was documentation at 4:00pm of FSBS readings were greater than 300 on 01/04/26 =	D 273		

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D 273	Continued From page 3	D 273		

497, 01/10/26 = 352, and 01/11/26 = 418.
-There was no documentation that FSBS checks were obtained at bedtime.
-There was no documentation that Resident #2's PCP was notified of the FSBS >300 from 01/01/26 - 01/13/26.

Telephone interview with the facility's contracted Nurse Practitioner (NP) on 01/14/26 at 10:23am revealed:
-Staff at the facility informed him that Resident #2's FSBS were elevated when he went into the facility every week or two.
-Staff should have telephoned him each time the FSBS readings were >300 and he would have ordered an additional dose of insulin and increased the resident's scheduled insulin.
-The resident had neuropathy in all four extremities and muscle wasting due to elevated blood glucose that would continue to get worse if FSBS continued to be elevated.
-The resident was at risk of a decline in organ function, hospitalization, and diabetic keto acidosis (a life-threatening acute complication of diabetes).

Interview with the Resident Care Coordinator (RCC) on 01/14/26 at 10:50am revealed:
-He administered medications and obtained FSBS readings Monday through Friday.
-He informed the PCP about the FSBS >300 when the PCP came to the facility.
-He did not notify the PCP each time the FSBS were >300 and would not provide an answer why he did not.

Interview with a medication aide (MA) on 01/15/26 at 9:51am revealed:
-She administered medications on the weekends.
-She did not notify the PCP when Resident #2's

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D 273	Continued From page 4 FSBS were >300. -It was the RCC's responsibility to notify the PCP. Interview with the Administrator on 01/14/26 at 12:19pm revealed: -The staff were trained to follow PCP orders. -The staff should have telephoned the PCP when Resident #2's FSBS were >300. -She did not know why staff did not notify the PCP. _____ The facility failed to notify Resident #2's Primary Care Provider related to FSBS results greater than 300, which put Resident #2 at risk of organ decline, diabetic keto acidosis, and hospitalization. This failure resulted in substantial risk for serious physical harm to the resident and constitutes a Type A2 Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 01/14/26. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED FEBRUARY 15, 2026.	D 273		
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.	D 358		

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D 358	Continued From page 5 This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 3 sampled residents (#2) related to a medication used to treat high blood glucose levels. The findings are: Review of Resident #2's current FL2 dated 05/22/25 revealed diagnoses included diabetes (a chronic disease that occurs when blood glucose levels are too high) and diabetic neuropathy (nerve damage caused by diabetes). Review of Resident #2's Resident Register revealed an admission date of 02/08/24. Review of Resident #2's physician's orders dated 12/03/25 revealed: -Humalog insulin (medication used to treat high blood glucose) 13 units with breakfast and lunch. -Humalog insulin 16 units with supper. -Check finger stick blood sugars (FSBS) before every meal and at bedtime. -Humalog sliding scale insulin (SSI) before meals for FSBS range 151-200 = 1 unit, 201-250 = 2 units, 251-300 = 3 units, 301-350 = 5 units, 351-400 = 7 units. -Humalog SSI at bedtime for FSBS range 201-250= 1 unit, 251-300 = 2 units, 301-350 = 3 units, 351-400 = 5 units. -Adjustments to Humalog dose: if FSBS < 60, delay injection until immediately after meal and reduce insulin by 4 units, for FSBS 61-80 immediately eat and take injection before eating and reduce insulin dose by 2 units, and for FSBS 81-150 take prescribed dose of insulin.	D 358		

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D 358	Continued From page 6 -Call Primary Care Provider (PCP) for FSBS >300. Observation of Resident #2's medications available for administration on 01/16/25 at 9:36am revealed there were six Humalog insulin pens dispensed on 11/06/25 and two remained. Review of Resident #2's laboratory results dated 07/18/25 revealed a hemoglobin A1C of 9.8 (a measure of the average blood glucose level over 2 to 3 months, normal is below 5.7) Telephone interview with a representative at the facility's contracted pharmacy on 01/15/26 at 8:00am revealed: -The pharmacy received signed physician's orders for Humalog SSI before meals for FSBS range 151-200 = 1 unit, 201-250 = 2 units, 251-300 = 3 units, 301-350 = 5 units, 351-400 = 7 units and Humalog SSI at bedtime for FSBS range 201-250= 1 unit, 251-300 = 2 units, 301-350 = 3 units, 351-400 = 5 units on 08/27/25 via fax for Resident #2. -The pharmacy last dispensed 6 pens of Humalog insulin to the facility on 11/06/25. Review of Resident #2's medication administration record (MAR) for December 2025 revealed: -There was an entry for Humalog SSI before meals for FSBS range 151-200 = 1 unit, 201-250 = 2 units, 251-300 = 3 units, 301-350 = 5 units, 351-400 = 7 units with administration times of 7:00am, 11:30am, and 4:30pm. -There was documentation of FSBS readings at 7:30am on 12/01/25 = 474, 12/02/25 = 281, 12/03/25 = 411, 12/04/25 = 188, 12/05/25 190, 12/07/25 = 177, 12/08/25 = 216, 12/11/25 = 201, 12/12/25 = 286, 12/13/25 = 520, 12/14/25 = 218,	D 358		

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D 358	Continued From page 7 12/16/25 = 168, 12/17/25 = 213, 12/18/25 = 256, 12/19/25 = 441, 12/20/25 = 509, 12/21/25 = 170, 12/22/25 = 261, 12/24/25 = 230, 12/25/25 = 216, 12/27/25 = 250, 12/29/25 = 248, 12/30/25 = 426, 12/31/25 = 215. -There was no documentation that any Humalog SSI was administered from 12/01/25 - 12/31/25 at 7:30am or reason why. -There was documentation of FSBS readings at 11:30am on 12/01/25 = 179, 12/02/25 = 372, 12/03/25 = 168, 12/04/25 = 201, 12/05/25 = 174, 12/06/25 = 157, 12/08/25 = 272, 12/12/25 = 180, 12/13/25 = 382, 12/15/25 = 247, 12/16/25 = 198, 12/17/25 = 389, 12/18/25 = 187, 12/19/25 = 455, 12/20/25 = 240, 12/21/25 = 321, 12/22/25 = 210, 12/23/25 = 256, 12/24/25 = 186, 12/25/25 = 266, 12/27/25 = 228, 12/28/25 = 181, 12/29/25 = 216, 12/30/25 = 230, 12/31/25 = 181. -There was no documentation that any Humalog SSI was administered from 12/01/25 - 12/31/25 at 11:30am or reason why. -There was documentation of FSBS readings at 4:30pm on 12/01/25 = 412, 12/02/25 = 205, 12/03/25 = 312, 12/04/25 = 342, 12/05/25 = 199, 12/06/25 = 198, 12/07/25 = 209, 12/08/25 = 462, 12/09/25 = 161, 12/10/25 = 163,12/12/25 = 281, 12/13/25 = 509, 12/14/25 = 183, 12/16/25 = 213, 12/17/25 = 591, 12/18/25 = 498, 12/19/25 = 450, 12/20/25 = 489, 12/21/25 = 458, 12/22/25 = 574, 12/23/25 = 156, 12/24/25 = 186, 12/25/25 = 194, 12/26/25 = 180, 12/27/25 = 260, 12/28/25 = 224, 12/29/25 = 260, 12/30/25 = 190, 12/31/25 = 156. -There was no documentation that any Humalog SSI was administered from 12/01/25 - 12/31/25 at 4:30pm or reason why. -There was an entry for Humalog SSI at bedtime for FSBS range 201-250 = 1 unit, 251-300 = 2 units, 301-350 = 3 units, 351-400 = 5 units with an administration time of 9:00pm. -There was no documentation of FSBS readings	D 358		

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D 358	Continued From page 8 or SSI administered from 12/01/25 - 12/31/25 at 9:00pm or reason why. Review of Resident #2's MAR for 01/01/26 - 01/13/26 revealed: -There was an entry for Humalog SSI before meals for FSBS range 151-200 = 1 unit, 201-250 = 2 units, 251-300 = 3 units, 301-350 = 5 units, 351-400 = 7 units with administration times of 7:00am, 11:30am, and 4:30pm. -There was documentation of FSBS readings at 7:30am on 01/01/26 = 219, 01/02/26 = 184, 01/03/26 = 219, 01/04/26 = 497, 01/05/26 = 193, 01/09/26 = 154, 01/10/26 = 182, 01/11/26 = 219, 01/12/26 = 325 and 01/13/26 = 230. -There was no documentation of any SSI administered on 01/01/26 - 01/13/26 at 7:30am or reason why. -There was documentation of FSBS readings at 11:30am on 01/02/26 = 226, 01/03/26 = 161, 01/04/26 = 262, 01/05/26 = 368, 01/06/26 = 425, 01/07/26 = 200, 01/08/26 = 210, 01/09/26 = 457, and 01/13/26 = 164. -There was no documentation of any SSI administered on 01/01/26 - 01/13/26 at 11:30am or reason why. -There was documentation of FSBS readings at 4:30pm on 01/01/26 = 189, 01/02/26 = 238, 01/03/26 = 213, 01/04/26 = 497, 01/05/26 = 156, 01/06/26 = 181, 01/09/26 = 189, 01/10/26 = 352, 01/11/26 = 418, 01/12/26 = 188, and 01/13/26 = 164. -There was no documentation of any SSI administered on 01/01/26 - 01/13/26 at 4:30pm or reason why. -There was an entry for Humalog SSI at bedtime for FSBS range 201-250= 1 unit, 251-300 = 2 units, 301-350 = 3 units, 351-400 = 5 units with an administration time of 9:00pm. -There was no documentation of FSBS readings,	D 358		

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D 358	Continued From page 9 or any SSI administered from 01/01/26 - 01/13/26 at 9:00pm or reason why. Interview with the Resident Care Coordinator (RCC) on 01/14/26 at 10:50am revealed: -He administered medications Monday through Friday. -He obtained Resident #2's FSBS readings three times a day and administered his scheduled insulin. -He did not obtain FSBS readings at bedtime and would not provide an answer why he did not. -He did not administer any SSI because he thought the orders were "confusing" and thought it "was ok not to administer it". -He telephoned Resident #2's endocrinologist about the SSI orders and was informed that the resident needed to come into the office before they would change the orders. -Resident #2 refused to go to see the endocrinologist. -He let the facility's contracted Nurse Practitioner (NP) know but did not inform the NP that the SSI was not being administered. Telephone interview with a medication aide (MA) on 01/15/26 at 9:51am revealed: -She did not administer SSI to Resident #2 because she could not locate Resident #2's MAR and thought the RCC took the MARs out of the facility. -She did not attempt to contact the RCC to bring the MARs back to the facility. -She did not say why she did not obtain FSBS readings at bedtime. Telephone interview with the facility's contracted NP on 01/14/26 at 10:23am revealed: -He managed Resident #2's insulin because the resident refused to see the endocrinologist.	D 358		

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-When he came to the facility, staff would inform him Resident #2's FSBS readings were high but he did not review the MARs.
-The facility should have contacted him if they thought the SSI orders were confusing.
-He was concerned that the bedtime FSBS readings were not obtained, and the SSI was not administered as ordered.
-The resident had neuropathy in all four extremities and muscle wasting due to high blood glucose and that would continue to get worse.
-The resident was at risk of a decline in organ function, hospitalization, and diabetic keto acidosis (a life-threatening acute complication of diabetes).

Interview with Resident #2 on 01/14/26 at 12:46pm revealed:
-He did not remember if staff obtained FSBS readings at bedtime or administered any SSI.
-He refused to go to the endocrinologist office and could not say why but he might go some time in the future.

Interview with the Administrator on 01/14/26 at 12:19pm revealed:
-She could not locate a policy on Medication Administration.
-The staff were trained to follow PCP orders.
-She knew Resident #2 refused to go to see the endocrinologist and staff should have telephoned the facility's contracted NP if orders were confusing.

Attempted telephone interview with Resident #2's Endocrinologist on 01/14/26 at 11:05am was unsuccessful.

_____

The facility failed to administer sliding scale insulin and obtain bedtime FSBS readings as

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D 358	Continued From page 11 ordered for Resident #2. This failure resulted in neglect to the resident and constitutes a Type A1 Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 01/14/26. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED FEBRUARY 15, 2026.	D 358		
D 456	10A NCAC 13F .1212(g) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (g) In the case of physical assault by a resident or whenever there is a risk that death or physical harm will occur due to the actions or behavior of a resident, the facility shall immediately: (1) seek the assistance of the local law enforcement authority; (2) provide additional supervision of the threatening resident to protect others from harm; (3) seek any needed emergency medical treatment; (4) make a referral to the Local Management Entity for Mental Health Services or mental health provider for emergency treatment of the threatening resident; and (5) cooperate with assessment personnel assigned to the case by the Local Management Entity for Mental Health Services or mental health provider to enable them to provide their earliest possible assessment. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to seek the assistance of local law	D 456		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCULLOUGH'S REST HOME	720 ORR'S CAMP ROAD HENDERSONVILLE, NC 28739

(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
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enforcement for 1 of 1 sampled residents (Resident #3), who exhibited aggressive behaviors.

The findings are:

Review of Resident #3's current FL2 dated 10/16/25 revealed diagnoses included coronary artery disease and high blood pressure.

Review of Resident #3's Resident Register revealed an admission date of 10/22/25.

Review of a hospital discharge summary dated 01/07/26 revealed an additional diagnosis of dementia.

Interview with the Resident Care Coordinator (RCC) on 01/14/26 at 3:05pm revealed:
-Resident #3 came to the doorway to the kitchen and asked for his 4:00pm medication on 01/13/26.
-The RCC attempted to hand a medication cup with the medication to Resident #3 and the resident slapped the cup out of the RCC's hand.
-The RCC was going to go get a replacement medication when Resident #3 became angry and grabbed a coffee pot off the dining room table and threw the coffee pot at him, but it missed and hit a dietary aid in the leg.
-The resident then picked up a telephone as if to throw it and the RCC walked up behind the resident and placed him in a bear hug restraint, lifted him up off the floor, and placed him in a sitting position on the couch in the dining room.
-The resident was yelling and cursing and was asked to stop and calm down.
-The resident calmed down and walked to his room.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL045005	A. BUILDING: _____ B. WING _____	R 01/16/2026

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Review of Resident #3's record on 01/16/26 revealed there was no documentation of the incident on 01/13/26.

Interview with the RCC on 01/16/26 at 9:10am revealed:
-He did not document the incident on 01/13/26 in the resident record, nor did he notify local law enforcement.
-He did not need to seek the assistance of local law enforcement because the resident calmed down and was no longer a threat to the safety of others.

Interview with the dietary aid on 01/14/25 at 3:07pm revealed:
-She was in the kitchen when Resident #3 slapped the medication cup out of the RCC's hand.
-She was hit in the legs with a coffee pot that Resident #3 threw at the RCC.
-She did not witness what occurred after that.

Interview with a resident on 01/14/26 at 3:42pm revealed he saw the RCC pick up Resident #3 under his armpits and placed him in a sitting position on the couch.

Interview with a second resident on 01/14/26 at 3:34pm revealed she saw the RCC grab the resident by wrapping his arms around him.

Interview with Resident #3 on 01/14/26 at 2:45pm revealed:
-He declined to discuss the restraint incident that occurred on 01/13/26.
-He knew the RCC would have a "different slant" on what occurred.
-There were other residents that witnessed the incident, but he would not say who they were.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL045005	A. BUILDING: _____ B. WING _____	R 01/16/2026

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D 456	Continued From page 14 Telephone interview with Resident #3's guardian on 01/15/26 at 10:00am revealed: -The Administrator always informed him of all incidents including an incident during the week of admission when the resident threw a nightstand at the Administrator. -Resident #3 could become irate and dangerous if he felt he was being lied to. -He did not know if staff notified local law enforcement or not. Interview with the Administrator on 01/16/26 at 9:02am revealed: -The facility did not a a policy and procedure for the use of Restraints because restraints were not used. -She knew about Resident #3's aggressive behavior on 01/13/26 and the guardian was notified. -The RCC did not contact local law enforcement because he was put into the bear hug restraint and then he "settled down". -She agreed that it was not necessary to contact local law enforcement.	D 456		
D 485	10A NCAC 13F .1501 (d) Use Of Physical Restraints And Alternatives 10A NCAC 13F .1501 Use Of Physical Restraints And Alternatives (d) The following applies to the restraint order as required in Subparagraph (a)(2) of this Rule: (1) The order shall indicate: (A) the medical need for the restraint based on the assessment and care plan; (B) the type of restraint to be used; (C) the period of time the restraint is to be used;	D 485		

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D 485	Continued From page 15 and (D) the time intervals the restraint is to be checked and released, but no longer than every 30 minutes for checks and no longer than two hours for releases. (2) If the order is obtained from a physician other than the resident's physician, the facility shall notify the resident's physician or physician extender of the order within seven days. (3) The restraint order shall be updated by the resident's physician or physician extender at least every three months following the initial order. (4) If the resident's physician changes, the physician or physician extender who is to attend the resident shall update and sign the existing order. (5) In an emergency, where the health or safety of the resident is threatened, the administrator or their designee, shall make the determination relative to the need for a restraint and its type and duration of use until a physician or physician extender is contacted. Contact with a physician shall be made within 24 hours and documented in the resident's record. For the purpose of this Rule, an "emergency" means a situation where there is a certain risk of physical injury or death to a resident. (6) The restraint order shall be kept in the resident's record. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure the primary care provider (PCP) was contacted and documented in the record within 24 hours after the use of an emergency restraint for 1 of 1 sampled residents (Resident #3).	D 485		

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D 485	Continued From page 16 The findings are: Review of Resident #3's current FL2 dated 10/16/25 revealed diagnoses included coronary artery disease and high blood pressure. Review of Resident #3's Resident Register revealed an admission date of 10/22/25. Review of a hospital discharge summary dated 01/07/26 revealed an additional diagnosis of dementia. Interview with the Resident Care Coordinator (RCC) on 01/14/26 at 3:05pm revealed: -Resident #3 came to the doorway to the kitchen and asked for his 4:00pm medication on 01/13/26. -The RCC attempted to hand a medication cup with the medication to Resident #3 and the resident slapped the cup out of the RCC's hand. -The RCC was going to go get a replacement medication when Resident #3 became angry and grabbed a coffee pot off the dining room table and threw the coffee pot at him, but it missed and hit a dietary aid in the leg. -The resident then picked up a telephone as if to throw it and the RCC walked up behind the resident and placed him in a bear hug restraint, lifted him up off the floor, and placed him in a sitting position on the couch in the dining room. -The resident was yelling and cursing and was asked to stop and calm down. -The resident calmed down and walked to his room. Review of Resident #3's record on 01/16/26 revealed: -There was no documentation of the incident on	D 485		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01/13/26.
-There was no documentation that Resident #3's PCP was contacted about the use of a restraint.

Interview with the RCC on 01/16/26 at 9:10am revealed:
-He did not document the incident on 01/13/26 in the resident record, nor did he contact the PCP.
-He informed the Administrator and she contacted Resident #3's guardian.
-The guardian managed all healthcare appointments and communicated with the PCP.

Interview with the dietary aid on 01/14/25 at 3:07pm revealed:
-She was in the kitchen when Resident #3 slapped the medication cup out of the RCC's hand.
-She was hit in the legs with a coffee pot that Resident #3 threw at the RCC.
-She did not witness what occurred after that.

Interview with a resident on 01/14/26 at 3:42pm revealed he saw the RCC pick up Resident #3 under his armpits and placed him in a sitting position on the couch.

Interview with a second resident on 01/14/26 at 3:34pm revealed she saw the RCC grab the resident by wrapping his arms around him.

Interview with Resident #3 on 01/14/26 at 2:45pm revealed:
-He declined to discuss the restraint incident that occurred on 01/13/26.
-He knew the RCC would have a "different slant" on what occurred.
-There were other residents that witnessed the incident, but he would not say who they were.

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D 485	Continued From page 18 Telephone interview with Resident #3's guardian on 01/15/26 at 10:00am revealed: -The Administrator always informed him of all incidents. -He had been responsible for communicating with the PCP and managed all appointments for Resident #3, but as of 01/02/26 the facility was responsible for that and he gave all contact numbers to the RCC. -He was not in his office the day of the incident but the Administrator informed the Adult Home Specialist (AHS) with the county Department of Social Services (DSS) of the incident. Interview with the Administrator on 01/16/26 at 9:02am revealed: -The facility did not have a policy and procedure for the use of Restraints because restraints were not used in the past. -She knew about Resident #3's aggressive behavior on 01/13/26 and the AHS was notified because the guardian was not in the office. -She did not contact Resident #3's PCP because she did not "figure it would do any good" because the resident was no longer having aggressive behaviors.	D 485		
D 487	10A NCAC 13F .1501 (f) Use Of Physical Restraints And Alternatives 10A NCAC 13F .1501 Use Of Physical Restraints And Alternatives (f) Physical restraints shall be applied only by staff who have received training on the use of alternatives to physical restraint use and on the care of residents who are physically restrained according to Rule .0506 of this Subchapter and have been validated on the care of residents who	D 487		

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D 487	Continued From page 19 are physically restrained and the use of care practices as alternative to restraints according to Rule .0504 of this Subchapter. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure staff were trained and validated on the use of restraints and the care of a restrained resident related to 1 of 1 sampled residents (Resident #3) who was restrained by staff. The findings are: Review of Resident #3's current FL2 dated 10/16/25 revealed diagnoses included coronary artery disease and high blood pressure. Review of Resident #3's Resident Register revealed an admission date of 10/22/25. Review of a hospital discharge summary dated 01/07/26 revealed an additional diagnosis of dementia. Interview with the Resident Care Coordinator (RCC) on 01/14/26 at 3:05pm revealed: -Resident #3 came to the doorway to the kitchen and asked for his 4:00pm medication on 01/13/26. -The RCC attempted to hand a medication cup with the medication to Resident #3 and the	D 487		

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resident slapped the cup out of the RCC's hand.
-The RCC was going to go get a replacement medication when Resident #3 became angry and grabbed a coffee pot off the dining room table and threw the coffee pot at him, but it missed and hit a dietary aid in the leg.
-The resident then picked up a telephone as if to throw it and the RCC walked up behind the resident and placed him in a bear-hug restraint, lifted him up off the floor, and placed him in a sitting position on the couch in the dining room.
-The resident was yelling and cursing and was asked to stop and calm down.
-The resident calmed down and walked to his room.

Review of Resident #3's record on 01/16/26 revealed there was no documentation of the incident on 01/13/26.

Interview with the RCC on 01/16/26 at 9:10am revealed:
-He did not document the incident with Resident #3 on 01/13/26 in the resident record.
-He did not receive any restraint training at the facility.
-He received training on the bear-hug restraint during prior military service and knew how to use it.

Review of the RCC's personnel record on 01/16/26 revealed there was not any documentation of restraint training.

Interview with the dietary aid on 01/14/25 at 3:07pm revealed:
-She was in the kitchen when Resident #3 slapped the medication cup out of the RCC's hand.
-She was hit in the legs with a coffee pot that

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D 487	Continued From page 21 Resident #3 threw at the RCC. -She did not witness what occurred after that. Interview with a resident on 01/14/26 at 3:42pm revealed he saw the RCC pick up Resident #3 under his armpits and placed him in a sitting position on the couch. Interview with a second resident on 01/14/26 at 3:34pm revealed she saw the RCC grab the resident by wrapping his arms around him. Interview with Resident #3 on 01/14/26 at 2:45pm revealed: -He declined to discuss the restraint incident that occurred on 01/13/26. -He knew the RCC would have a "different slant" on what occurred. -There were other residents that witnessed the incident, but he would not say who they were. Interview with the Administrator on 01/16/26 at 9:02am revealed: -The facility did not have a policy and procedure for the use of restraints because restraints were not used. -The RCC restrained the resident because he was having aggressive behavior and needed to "calm down" and she thought it was appropriate to do that. -There was not any restraint training at the facility because the facility never had a need to use restraints. -She did not know where the RCC learned the bear-hug restraint. _____ The facility failed to ensure staff were trained on the use of restraints and alternative to restraints before placing Resident #3 in a bear hug hold restraint. This failure was detrimental to the	D 487		

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D 487	Continued From page 22 health and safety of the resident and constitutes a Type B Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 01/21/26. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 2, 2026.	D 487		