Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HA1845805	A. BUILDING _____ B. WING _____	R 01/22/2025

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

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)	COMPLETION DATE
D 000	Initial Comments The Adult Care Licensure Section and the Henderson County Department of Social Services conducted an annual and follow up survey and a complaint investigation on 01/22/25. The complaint investigation was initiated by the Henderson County Department of Social Services on 12/17/24.	D 000	AN APPOINTMENT WAS CONSTRUCTED ASAP HE HAS AN APPT 1-30-25 WHICH HE ATTENDED. A SHEET WAS PUT TOGETHER TO MONITOR RESIDENTS TOE/NAILS + FINGERNAILS WEEKLY SHEET IS PROVIDED WITH RESPONSE TO SAID DEFICIENCY. PT IS SCHEDULED FOR FOOT CARE EVERY MONTH. FINGERNAILS WILL BE CUT WEEKLY BY STAFF/HOMEHEALTH	2-28-25
D 209	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to provide personal care assistance for 1 of 3 sampled residents (#1) who required assistance with nail care and had fingernails and toenails that were yellowed, long, and jagged. The findings are: Review of Resident #1's PL2 dated 07/09/24 revealed diagnoses included cellulitis of the scrotum. Review of Resident #1's Resident Register revealed an admission date of 01/07/15. Review of Resident #1's Care Plan dated 08/03/24 revealed: -The resident was forgetful and needed	D 209		

Division of Health Service Regulation

Virginia McCullough 3-6-25

STATE FORM 6899 (R) DATE

Reviewed and acknowledged 3/7/25

RP

Division of Health Service Regulation

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HA1045005	A. BUILDING: _____ B. WING _____	R 01/22/2025

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

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) COMPLETION DATE
I 269	Continued From page 1 reminders. •The resident required extensive staff assistance with bathing, dressing, and grooming/personal hygiene. 1. Observation of Resident #1's hands on 01/22/25 at 11:10am revealed: -The fingernails on the resident's right and left hands were yellowed, long, and jagged. -The thumbnail on the resident's right hand was [illegible] jagged [illegible] half of the nail missing. Interview with Resident #1 on 01/22/25 at 11:10am revealed: -He knew his fingernails were long. -He was able to cut his own fingernails. -He did not know how long it had been since his fingernails had been cut. -He would rather cut his own fingernails than to have staff help him. Interview with a medication aide (MA) on 01/22/25 at 11:35am revealed: •Resident #1's fingernails were very long. -Resident #1 was not able to cut his own fingernails. -Resident #1 was resistant to staff assistance with nail care. Interview with the Administrator on 01/22/25 at 12:10pm revealed: -She and the staff had offered to cut Resident #1's fingernails, but he would not let them cut them. -She had offered to take Resident #1 to a nail salon to get his nails cut and he refused. •She convinced Resident #1 to file his own nails "once in awhile." -Resident #1 would not accept nail care from the home health registered nurse (RN) who saw him	I 269		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL0[illegible]5	A. BUILDING: _____ B. WING _____	R 01/22/2025

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) COMPLETION DATE
D 289	Continued From page 2 two to three times a week. Attempted interview with Resident #1's home health RN on 01/22/25 at 10:57am was unsuccessful. Attempted interview with Resident #1's home health agency Clinical Manager on 01/22/25 at 11:00am was unsuccessful. 2. Observation of Resident #1's feet with a medication aide (MA) present on 01/22/25 at 12:08pm revealed: -Resident #1's left great toenail was yellowed, thick, long, and jagged and protruded approximately 1/4 inch past the tip of the toe. -Resident #1's toenails on his left foot were yellow in color, thick, long, and jagged. -Resident #1's toenails on his right foot were yellow in color, thick, long, and jagged. Interview with a medication aide (MA) on 01/22/25 at 11:35am revealed: -He knew Resident #1's toenails were long and thick and needed to be cut. -He had taken Resident #1 to a local podiatrist for foot care until the business recently closed. -He had been trying to get Resident #1 an appointment at another podiatry office, but an appointment had not yet been available.	D 289		
D 396	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication	D 396		

Virginia McCullough 3-6-25

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NALD45605	A. BUILDING: _____ B. WING _____	R 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
...CULLOUGH'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 366	Continued From page 3 immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-chenting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication aide (MA) observed re...dents take their medications for 2 of 3 sample ...sidents (#3 and #4) related to cups of medicati... observed on tables in the residents' rooms. The findings are: 1. Review of Resident #3's current FL2 dated 11/27/24 revealed diagnoses included depression and schizophrenia. Observation of Resident #3's room during the initial tour on 01/22/25 at 8:46am revealed there was a medication cup on the bedside table that contained 4 medication tablets. Review of physician's order for Resident #3 revealed: -There was an order for lamotrigine (treats bipolar disorder) 25mg take two tablets daily dated 11/27/24. -There was an order for trazodone (treats depression) 100mg at bedtime dated 11/27/24. -There was an order for olanzapine (treats schizophrenia) 5mg twice daily dated 12/06/24. Review of Resident #3's medications available for administration on 01/22/24 at 10:00... revealed: -There was one bubble pack labeled ...notrigine 25mg take two tablets daily and 32 ...und tablets	D 366	WE CONDUCTED AN INSERVICE MEDICATION ADMINISTRATION CLASS. ON 2-4-25. THE RULES ARE BEING FOLLOWED WITH THE ADMINISTRATION OF MEDICATION. RESIDENTS ARE TAKING MEDS IN THE PRESENCE OF MA, AN INSERVICE SHEET IS PROVIDED WITH SAID DEFICIENCY. WE ALSO HAVE	

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STATE FORM

Virginia McCullough 3-6-25

If continuation sheet 4 of 8

FORM APPROVED

Division of Health Service Regulation

(X1) STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X2) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X3) MULTIPLE CONSTRUCTION	(X4) DATE SURVEY COMPLETED
	HAL046065	A. BUILDING: _____ B. WING _____	R 01/22/202

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CULLOUGH'S REST HOME	720 DRIFT 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) COMPLETION DATE
D 368	Continued From page 4 remained. -There was two bubble packs labeled olanzapine 5mg twice daily and 17 round tablets remained in one bubble pack and 16 in the second. -There was one bubble pack labeled trazodone 100mg at bedtime and 16 round tablets remained in the bubble pack. Review of Resident #3's MAR for [redacted] 1/25 - 01/21/25 revealed: -There was an entry for lamotrigine 25mg take two tablets daily with an administration time of 8:00am and documentation the lamotrigine was administered at 8:00am on 01/01/25 - 01/21/25. -There was an entry for olanzapine 5mg twice daily with administration times of 8:00am and 8:00pm and documentation the olanzapine was administered at 8:00am and 8:00pm on 01/01/25 - 01/21/25. -There was an entry for trazodone 100mg at bedtime with an administration time of 8:00pm and documentation the trazodone was administered at 8:00pm on 01/01/25 - 01/21/25. Interview with Resident #3 on 01/22/25 at 8:47am revealed: -The medications in the cup were his evening medications from the previous day. -The Medication Aide (MA) forgot to observe him take his medications and he forgot to take them. Interview with the MA on 01/22/25 at 8:58am revealed that sometimes Resident #3 would keep the medications under his tongue and he thought the resident had swallowed them. Refer to the telephone interview with the facility's contracted Nurse Practitioner (NP) on 01/22/25 at 11:00am.	D 368	[redacted] (RN nurse consultant) IS CONDUCTING AN AUDIT AND EVERY TWO WEEKS SHE IS MONITORING BEDSIDE TO SEE IF MEDICATIONS IS BEING LEFT AT BEDSIDE, SHE COMMENCED 1-5-25 A MED BY BEDSIDE AUDIT.	

Division of Health Service Regulation
STATE FORM [redacted] 6899 11

Virginia McCullough 3-7-25

If continuation sheet 5 of 8

...ision of Health Service Regulation

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 _____	01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CULLOUGH'S REST HOME	720 ORR'S CAMP ROAD LAURINBURG, NC 28352

(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 366	Continued From page 5 Refer to the interview with the Administrator on 01/22/25 at 10:50am. 2. Review of Resident #4's Warrant FL2 dated 05/27/24 revealed diagnoses of schizoaffective disorder. Review of physician's orders for Resident #4 revealed: -There was an order for escitalopram oxalate (treats depression) 5mg three times daily dated 05/27/24. -There was an order for gabapentin (treats pain) 300mg four times daily dated 08/19/24. -There was an order for buspirone (treats anxiety) 15mg three times daily and benztropine (antipsychotic medication) 0.5mg twice daily dated 09/04/24. Observation of Resident #4's room during the initial tour on 01/22/25 at 9:00am revealed: -There were three medication cups on the dresser and one medication cup contained one yellow capsule, a second medication cup contained one yellow capsule, two round tablets, and one rectangle tablet, a third medication cup contained one yellow capsule and one round tablet. -There were two yellow capsules on the dresser next to the medication cups. -There was a fourth medication cup on a table next to the bed that contained one yellow capsule, two round tablets, and one rectangle tablet. Observations of Resident #4's medication available for administration on 01/22/25 at 10:53 am revealed: -There were two bubble pack labeled benztropine 0.5mg twice daily and 17 round tablets remained	D 366		

Virginia McCullough 3-6-25

ID: ision of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL645005	A. BUILDING: _____ B. WING _____	R 01/22/202

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

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)	COMPLETION DATE
D 366	Continued From page 9 in one bubble pack and 18 in the second. -There was one bubble pack labeled buspirone 15mg three times daily and 15 rec ·gle tablets remained. -There was one bubble pack labele : escitalopram 5mg three times daily and 8 round tablets remained in the bubble pack. •There were four bubble packs labeled gabapentin 300mg four times daily and 26 yellow capsules remained in one bubble pack, 17 in the second, 16 in the third, and 24 in the fourth bubble pack. Review of Resident #4's Medication Administration Record (MAR) for 01/01/25 - 01/21/25 revealed: -There was an entry for benztropine 0.5mg twice daily with administration times 8:00am and 8:00pm and documentation the benztropine was administered at 8:00am and 8:00pm on 01/01/25 - 01/21/25. -There was an entry for buspirone 15mg three times daily with administration times of 8:00am, 12:00pm, and 8:00pm and documentation the buspirone 15mg was administered at 8:00am, 12:00pm, and 8:00pm on 01/01/25 - 01/21/25. -There was an entry for gabapentin 300mg four times daily with administration times of 8:00am, 12:00pm, 4:00pm, and 8:00pm and documentation the gabapentin was ·· ministered at 8:00am, 12:00pm, 4:00pm, and 8:00pm on 01/01/25 - 01/21/25. -There was an entry for escitalopram 5mg three times daily with administration times of 8:00am, 12:00pm, and 8:00pm and documentation the escitalopram was administered at 8:00am, 12:00pm, and 8:00pm on 01/01/25 - 01/21/25. Interview with Resident #4 on 01/22/25 at 11:06am revealed sometimes the MA did not	D 366		

Virginia McCullough 3-6-25

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HA1045085	A. BUILDING: _____ B. WING _____	R 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CULLOUGH'S REST HOME	749 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 368	Continued From page 7 observe him swallow his medication and left the medications in his room and then would forget to take the medications. Interview with the Resident Care Coordinator (RCC) on 01/22/25 at 11:05am revealed: -He administered the morning, afternoon, and evening medications to Resident #4. -He was sure he observed Resident #4 take his medications and did not know why the medications were in the room. Refer to the telephone interview with the facility's contracted NP on 01/22/25 at 11:00am. Refer to the interview with the Administrator on 01/22/25 at 10:50am. Telephone interview with the facility's contracted NP on 01/22/25 at 11:00am revealed: -Staff should have questioned the residents why they were not taking their medications when medications were found in the rooms. -Staff should ensure residents take their medications and not leave them in the rooms. Interview with the Administrator on 01/22/25 at 10:50am revealed: -The RCC administered the morning, afternoon, and evening medications. -The RCC should have observed the residents take their medications. -She did not know why the RCC left the medications in the rooms.	D 368		

Virginia McCullough 3-6-25