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|---|---|
| MCCULLOUGH'S REST HOME | 720 ORR'S CAMP ROAD HENDERSONVILLE, NC 28739 |

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| D 000 | Initial Comments<br><br>The Adult Care Licensure Section conducted a follow-up survey and complaint investigation on 04/14/26-04/16/26. The complaint investigations were initiated by the Henderson County Department of Social Services on 03/10/26 and 03/31/26. | D 000 | | |
| D 105 | 10A NCAC 13F .0311 (a) Other Requirements<br><br>10A NCAC 13F .0311 Other Requirements<br><br>(a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition.<br><br>This Rule is not met as evidenced by:<br>TYPE B VIOLATION<br><br>Based on observations and interviews, the facility failed to properly maintain a toilet in 1 of 2 common resident bathrooms.<br><br>The findings are:<br><br>Interview with one resident during the initial facility tour on 04/14/26 at 9:55am and on 04/15/26 at 11:50am revealed:<br>-The toilet at the end of the left hallway from the living room overflowed into her bedroom.<br>-In January or February 2026, she was in her room sleeping and the toilet stopped up and | D 105 | | |

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overflowed into her room.
-There was at least three inches of water on her floor.
-The toilet flush valve was not working properly and did not allow enough water into the back of the tank to completely flush the contents of the toilet bowl.
-She had to take the back off the toilet tank and lift the flush valve to allow more water into the toilet reservoir tank so the toilet would flush completely.
-She did not put used toilet paper into the toilet bowl but put it into the garbage because the toilet would not flush properly.
-She had to flush the toilet two or three times before the contents of the toilet bowl would empty.
-The Maintenance staff attempted to fix the toilet, but the flush valve was still not allowing enough water into the toilet reservoir to adequately flush the toilet.
-The toilet overflowed two times into her room since the flush valve was replaced.
-She kept a blanket down at the bottom of her door to keep the water out of her room.
-The toilet had overflowed into her room four times since she moved into the room.

Interview with a second resident on 04/15/26 at 1:32pm revealed:
-He used the common bathroom toilet at the end of the left hallway.
-The toilet needed more water in the tank.
-The toilet was not flushing right.
-The toilet had not been flushing right for "awhile."
-The toilet had never overflowed into his room.
-The toilet needed more water to flush the sewage down.

Observation of the common bathroom at the end

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of the left hallway on 04/15/26 at 11:17am revealed:
-The toilet had human waste and paper in the toilet bowl.
-An attempted flush of the toilet did not provide enough water to flush the contents in the toilet bowl.

Interview with the Resident Care Coordinator (RCC) on 04/15/26 at 11:17am revealed:
-The toilet in the common bathroom at the end of the left hallway was not working "right".
-The toilet was used by all residents and staff.
-The Maintenance staff said he was going to replace the entire toilet to fix the problem.
-The new handle Maintenance staff put in the toilet was not strong enough to flush the toilet.
-The toilet had been difficult to flush for "a week or two."
-You had to flush the toilet three or four times before the toilet bowl contents would go down.

Interview with the Housekeeper on 04/15/26 at 11:29am and 11:48am revealed:
-There were five residents that used the common bathroom at the end of the left hallway.
-The toilet would overflow when the residents put too much paper into the toilet bowl and the paper would not go down.

Telephone interview with Maintenance staff on 04/15/26 at 11:45am revealed:
-The facility needed a new toilet installed in the left hallway common bathroom.
-The toilet overflowed a month ago.
-He put a new flush valve in the toilet a month ago so it would not overflow.
-The diameter of the sewage pipe under the toilet was small.
-He had to take the toilet off completely and

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| D 105 | Continued From page 3<br>unblock the sewage drainage pipe "last year."<br>-He would be out on Friday (04/17/26) to replace the toilet.<br><br>Interview with the RCC on 04/16/26 at 9:30am revealed:<br>-The toilet in the common bathroom at the end of the left hallway had not been flushing correctly for two weeks.<br>-The Maintenance staff told him they needed a new toilet.<br>-One resident told him the toilet had overflowed into her room, and she and a family member cleaned it up.<br><br>Interview with the Administrator on 04/16/26 at 11:45am revealed:<br>-She did not know the toilet at the end of the left hallway was not working correctly.<br>-She did not know the toilet had overflowed into a resident room.<br>-She did a walk-through of the facility to check on environmental issues once a month.<br>-She and the RCC were responsible for notifying maintenance about repairs that were needed in the building.<br><br>_____<br>The facility failed to repair a common bathroom toilet which did not flush properly and overflowed into a resident room on four occasions and with one occasion resulting in three inches of water in the resident's room. This failure was detrimental to the health, safety, and welfare of the residents and constituted a Type B Violation.<br><br>_____<br>The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/15/26 for this violation.<br><br>CORRECTION DATE FOR THE TYPE B | D 105 | | |

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| D 105 | Continued From page 4<br>VIOLATION SHALL NOT EXCEED MAY 31, 2026. | D 105 | | |
| D 139 | 10A NCAC 13F .0407(a)(7) Other Staff Qualifications<br><br>10A NCAC 13F .0407 Other Staff Qualifications<br>(a) Each staff person at an adult care home shall:<br>(7) have a criminal background check completed in accordance with G.S. 131D-40 and results available in the staff person's personnel file;<br><br>This Rule is not met as evidenced by:<br>Based on interviews, and record reviews, the facility failed to complete a criminal background check or obtain a consent for a criminal background check on 1 of 3 sampled staff (Staff A).<br><br>The findings are:<br><br>Review of Staff A's personnel record revealed:<br>-There was documentation that Staff A was employed as a personal care aide.<br>-There was no documentation of Staff A's hire date.<br>-There was no documentation of a consent for a criminal background check.<br>-There was no documentation of a criminal background check prior to being hired.<br><br>Interview with the Administrator on 04/16/26 at 8:50am revealed:<br>-She hired Staff A as a personal care aide.<br>-She was responsible for maintaining the staff records.<br>-She was aware employees required a background check. | D 139 | | |

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| D 139 | Continued From page 5<br>-She attempted to obtain a criminal background check for Staff A approximately 1 year ago, but the Clerk of Courts office was not available.<br>-She forgot to go back to obtain a criminal background check on Staff A.<br>-Staff A was no longer employed by the facility.<br>-Staff A resigned on 04/15/26. | D 139 | | |
| D 269 | 10A NCAC 13F .0901(a) Personal Care and Supervision<br><br>10A NCAC 13F .0901 Personal Care and Supervision<br>(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.<br><br>This Rule is not met as evidenced by:<br>TYPE B VIOLATION<br><br>Based on interviews and record reviews, the facility failed to provide incontinence care to 1 of 3 sampled residents (Resident #2) who required staff assistance with personal care and hygiene.<br><br>The findings are:<br><br>Review of Resident #2's current FL2 dated 01/07/26 revealed:<br>-Diagnoses included cachexia (a complex often irreversible syndrome driven by inflammation and metabolic changes linked to severe chronic illnesses causing significant, involuntary loss of body weight, fat, and muscle mass.) and difficulty walking.<br>-Resident #2 was non-ambulatory and incontinent of bowel. | D 269 | | |

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| D 269 | Continued From page 6<br><br>Review of Resident #2's Resident Register revealed an admission date of 11/20/25.<br><br>Review of Resident #2's Care Plan dated 02/10/26 revealed:<br>-Resident #2 had occasional incontinence of bladder and bowel.<br>-Resident #2 was totally dependent for toileting, ambulation/locomotion, bathing, dressing, grooming/personal hygiene, and transfers.<br><br>a. Telephone interview with a Registered Nurse (RN) who worked at a local hospital on 04/14/26 at 1:55pm revealed:<br>-On 03/04/26, Resident #2 was brought to the hospital for a Computed Tomography (CT) scan (a diagnostic imaging procedure that uses a combination of X-rays and computer technology to produce images of the inside of the body) of his legs and neck.<br>-When the RN assisted other hospital staff to lift Resident #2 out of his wheelchair to place him on the CT table, there was dried feces all over his chair and body.<br>-There was dried fecal material in the wheelchair, on the front and back of Resident #2's body, and under his fingernails.<br>-The fecal material had been there "well over a day."<br>-Resident #2 had "skin breakdown" in his groin and perineum.<br>-Resident #2's skin was red and very tender as hospital staff cleaned Resident #2.<br>-Resident #2 told the RN the facility staff had woken him up and put him in the van to go to the appointment.<br>-Resident #2 told the RN he had uncontrolled bowel movements.<br>-He called the facility to let staff know the | D 269 | | |

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| D 269 | Continued From page 7<br>condition they had found Resident #2.<br><br>Interview with Resident #2 on 04/14/26 at 9:25am revealed:<br>-On 03/04/26 when he went to the hospital for a CT scan, he had been "rushing" and trying to get his "stuff" together to get to the appointment.<br>-He dressed himself on the morning of 03/04/26 before going to the hospital for a CT scan.<br>-He transferred himself into his wheelchair using a transfer board.<br>-He was "clean" when he left the facility.<br>-He may have soiled himself in the medical taxi on the way to the hospital.<br>-The hospital staff "cleaned" him up at the hospital.<br><br>Telephone interview with Resident #2's Primary Care Provider (PCP) on 04/14/26 at 2:20pm revealed:<br>-Resident #2 had no control over his bowels and stool "seeps" out without the resident knowing it.<br>-He wrote an order for adult briefs for Resident #2 to manage the incontinence.<br>-He had not evaluated the condition of the skin in Resident #2's perineum or groin area.<br><br>Telephone interview with Resident #2's PCP on 04/16/26 at 8:36am revealed:<br>-Dried feces left on a person's skin could cause skin breakdown.<br>-The risk of skin breakdown included progression to necrosis (the premature, accidental death of cells and living tissue, typically caused by external factors such as infection, injury, toxins, or lack of blood flow) and decubitus (injuries to the skin and underlying tissue caused by prolonged pressure on the skin).<br>-Resident #2 had sensation in his lower extremities but not movement. | D 269 | | |

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-Resident #2 had poor circulation in his lower extremities due to smoking and muscle wasting.
-He did not doubt the hospital staff found feces on Resident #2 on 03/04/26 because he "leaks" stool.
-But he did not know if the hospital staff found "dried" feces because he did not see it.
-He saw Resident #2 in the past with small amounts of stool on him.
-He did not know if Resident #2 knew when he had an incontinent episode.
-Resident #2 was able to clean himself.
-Resident #2 was "fully alert".
-Resident #2 required a lot of assistance from staff with activities of daily living (ADLs).

Interview with the RCC on 04/16/26 at 9:30am revealed:
-Resident #2 got himself up and ready on 03/04/26 to go to the hospital for the CT scan.
-He was not at the facility when Resident #2 left for the hospital on 03/04/26.
-The Administrator was present and in charge of the building when Resident #2 went to the hospital on 03/04/26.
-Resident #2 did not frequently ask for assistance from staff even though he told him to let staff help him.
-The hospital staff called the Administrator and told her about the feces found on Resident #2.
-Then the hospital staff called him.

Interview with the Administrator on 04/16/26 at 11:45am revealed:
-On 03/04/26, she was in the building while the RCC was at an appointment.
-She was responsible for assisting residents with personal care in the absence of the RCC.
-Resident #2 "just left."
-Resident #2 did not tell her he was going to the

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| D 269 | Continued From page 9<br><br>CT scan appointment.<br>-The cab which transported Resident #2 to the hospital was 30 minutes early.<br>-She did not know Resident #2 was soiled and required incontinence care.<br>-She found out when hospital staff called the RCC.<br>-The hospital staff told her they had to shower Resident #2 before they could do the CT scan.<br><br>b. Interview with Resident #2 during the initial tour on 04/14/26 at 9:25am revealed:<br>-He showered himself by "pulling himself in and out" of the shower.<br>-It was hard for him to take a shower.<br>-He used wipes and a bucket of water two times a week instead of showering.<br>-He used wipes and a bucket of water to clean himself when his legs hurt and he did not "feel good".<br>-The staff did assist him with showers also.<br>-The Resident Care Coordinator (RCC) helped him to shower last on Friday (04/10/26).<br>-He also received a shower on Wednesday (04/08/26).<br>-"Sometimes" he allowed staff to assist him with showers and sometimes he would shower himself or use wipes and a bucket of water, it just all depended on how he felt.<br>-He was unable to reach his feet.<br>-He did not have sores on his feet, but there was dead skin on them.<br>-The staff were aware of the condition of his feet.<br>-His Primary Care Provider (PCP) was aware of the condition of his feet.<br>-The staff sprayed antifungal spray on his feet every other day.<br><br>Observation of Resident #2's feet on 04/14/26 at 9:32am revealed: | D 269 | | |

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| D 269 | Continued From page 10<br>-There was swelling in Resident #2's feet.<br>-Resident #2's right foot had areas of brown discoloration on the skin and areas of flaking skin.<br>-Resident #2's left foot had areas of brown discoloration on the skin and areas of flaking skin.<br><br>Review of Resident #2's PCP order dated 02/10/26 revealed Desenex Spray 2% (an over-the-counter antifungal medication used to treat athlete's foot by relieving burning, itching, and scaling) to both feet three times a day for 14 days.<br><br>Review of Resident #2's February 2026 Medication Administration Record (MAR) revealed:<br>-There was a hand written entry for Lotrimin AF 2% spray apply topically to feet three times a day for 14 days scheduled for 8:00am, 12:00pm, and 8:00pm.<br>-The Lotrimin AF 2% spray was documented as administered as ordered from 02/11/26-02/24/26.<br><br>Interview with the Resident Care Coordinator (RCC) on 04/14/26 at 2:00pm revealed:<br>-He assisted Resident #2 with showers.<br>-There was an order for antifungal spray for Resident #2's feet.<br><br>Telephone interview with Resident #2's PCP on 04/16/26 at 8:36am revealed:<br>-He was aware of the condition of Resident #2's feet.<br>-He ordered antifungal spray to be applied to Resident #2's feet.<br><br>_____<br>The facility failed to ensure that Resident #2 received assistance with incontinence care, as | D 269 | | |

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| D 269 | Continued From page 11<br>the resident arrived at an appointment soiled with dried feces after traveling from the facility in a taxi placing him at increased risk for skin breakdown that could progress to a decubitus ulcer with necrosis on his buttocks. The facility also failed to provide necessary assistance with foot care while he was being treated for a fungal infection placing him at an increased risk for skin breakdown and an ongoing fungal infection on his feet. This failure was detrimental to the health, safety and welfare of the resident and constitutes a Type B Violation.<br>_____<br>The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/16/26 for this violation.<br><br>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 31, 2026. | D 269 | | |
| D 273 | 10A NCAC 13F .0902(b) Health Care<br><br>10A NCAC 13F .0902 Health Care<br>(b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.<br><br>This Rule is not met as evidenced by:<br>FOLLOW-UP TO TYPE A2 VIOLATION.<br><br>The Type A2 Violation was abated.<br>Non-compliance continues.<br><br>TYPE B VIOLATION<br><br>Based on observations, interviews, and record reviews, the facility failed to ensure referral and | D 273 | | |

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follow-up to meet the routine and acute health care needs for 2 of 4 sampled resident (Residents #2 and #4) related to a podiatry referral (#2), failure to notify the mental health provider (MHP) of a hospital evaluation (#4), and failure to notify the primary care provider (PCP) a medication used to treat high blood pressure was not available (#4).

The findings are:

1. Review of Resident #2's current FL2 dated 01/07/26 revealed:
-Diagnoses included cachexia (a complex often irreversible syndrome driven by inflammation and metabolic changes linked to severe chronic illnesses causing significant, involuntary loss of body weight, fat, and muscle mass.) and difficulty walking.
-Resident #2 was non-ambulatory.

Review of Resident #2's Resident Register revealed an admission date of 11/20/25.

Review of Resident #2's Care Plan dated 02/10/26 revealed:
-Resident #2 was ambulatory with use of a wheelchair.
-Resident #2 had limited upper body strength.
-Resident #2 was totally dependent for toileting, ambulation/locomotion, bathing, dressing, grooming/personal hygiene, and transfers.

Review of Resident #2's PCP order dated 02/10/26 revealed follow-up with podiatry.

Interview with Resident #2 during the initial tour on 04/14/26 at 9:25am revealed:
-He was unable to reach his feet to cut his toenails.

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| D 273 | Continued From page 13<br>-He was supposed to go to the foot doctor "sometime".<br>-He did not have sores on his feet, but there was dead skin on them and the toenails were long.<br>-His feet were painful to him when he accidentally ran over them with his wheelchair or hit his feet against objects.<br>-He could not wear shoes because it was too painful due to the length of his toenails.<br>-The staff were aware of the condition of his feet and toenails.<br>-The staff sprayed antifungal spray on his feet every other day.<br><br>Observation of Resident #2's feet on 04/14/26 at 9:32am revealed:<br>-There was swelling in Resident #2's feet.<br>-Resident #2's right foot had areas of brown discoloration on the skin and areas of flaking skin.<br>-The great toenail on Resident #2's right foot was thick, rough, dark brown in color, and protruded approximately 1/2 inch from the flesh of the toe.<br>-The remaining toenails on Resident #2's right foot were thick, rough, and dark brown in color.<br>-Resident #2's left foot had areas of brown discoloration on the skin and areas of flaking skin.<br>-The great toenail on Resident #2's left foot was thick, rough, dark brown in color, and protruded approximately 3/4 inch from the flesh of the toe and curled down at the top.<br>-The remaining toenails on Resident #2's left foot were thick, rough, and dark brown in color.<br><br>Interview with the Resident Care Coordinator (RCC) on 04/14/26 at 2:00pm revealed:<br>-He assisted Resident #2 with showers and he provided hygiene assistance after incontinent occurrences. | D 273 | | |

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-He made an appointment with podiatry, but the podiatry practice would not take Resident #2's type of insurance.
-He had not yet made another podiatry appointment for Resident #2, as he was having trouble finding a provider that accepted Resident #2's insurance.
-There was an order to sprayed antifungal spray on Resident #2's feet, but Resident #2 needed his toenails cut.

Telephone interview with Resident #2's PCP on 04/16/26 at 8:36am revealed:
-He was aware of the condition of Resident #2's feet and toenails.
-He ordered a referral to podiatry on 02/10/26.
-His understanding was the facility staff were having trouble finding a podiatry office that would take Resident #2's insurance.
-They had to work within the time frame of how long it took to find a specialist who was willing to take Resident #2's insurance.

Interview with the Administrator on 04/16/26 at 11:45am revealed the RCC should have notified Resident #2's PCP on that the podiatry appointment was cancelled on 03/31/26 and about the challenges of finding a provider for the podiatry care.

2. Review of Resident #4's current FL2 dated 01/07/26 revealed diagnosis included schizophrenia.

a. Review of Resident #4's emergency medical service (EMS) report dated 03/12/26 revealed:
-History of chronic obstructive pulmonary disease, hypertension. pneumonia, schizophrenia, and substance use disorders.
-Resident #4's blood pressure at 7:57pm was

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173/104 and his pulse was 112.
-Resident # 4's pulse at 8:04pm was 127.

Review of Resident #4's local emergency department (ED) discharge summary dated 03/12/26 revealed:
-Resident #4 presented to the ED via EMS after he generally felt unwell.
-Resident #4 complained of lightheadedness, feelings of shakiness, and a subjective concern that his blood pressure was high.

Interview with Resident #4 on 04/15/26 at 9:30am revealed he had asked to go to the ED on 03/12/26 because his blood pressure "shot up way up".

Interview with the Resident Care Coordinator (RCC) on 04/15/26 at 9:42am revealed:
-On 03/12/26, Resident #4 told him he did not feel "right" but he did not want to go to the ED for evaluation.
-Resident #4 did ask to go to the ED later that same day.
-The evening staff sent Resident #4 to the ED on 03/12/26.

Telephone interview with a PCA on 04/15/26 at 10:25am revealed:
-He sent Resident #4 out to the hospital on 03/12/26.
-Resident #4 told him he was feeling lightheaded and like he was going to pass out and he wanted to go to the ED.
-When Resident #4 returned from the hospital, he left the hospital discharge summary on the RCC's desk.
-The RCC was responsible for processing the hospital discharge paperwork.
-The RCC was responsible for notifying Resident

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#4's mental health provider (MHP) concerning the hospital visit.

Telephone interview with Resident #4's lead of mental health team on 04/15/26 at 10:50am revealed:
-The facility staff did not notify the MHP of Resident #4's visit to the ED on 03/12/26.
-The MHP was not told why Resident #4 went to the ED on 03/12/26.
-They would expect facility staff to call the crisis line to report anytime one of their clients was hospitalized.

Interview with the RCC on 04/15/26 at 1:48pm revealed:
-He was responsible for processing Resident #4's ED paperwork from the 03/12/26 visit.
-He "may have told" Resident #4's mental health nurse about the ED visit on 03/12/26.
-He was "not sure" if he told Resident #4's mental health nurse or not about Resident #4's visit to the ED on 03/12/26 or not.

Interview with the Administrator on 04/16/26 at 11:45am revealed:
-The PCA who had sent Resident #4 out to the ED on 03/12/26 did not say anything to her about Resident #4's ED visit on 03/12/26.
-She would have contacted the MHP if she had known.
-She and the RCC were responsible for contacting the MHP.
-She did not become aware of the incident with Resident #4 until 04/15/26.

b. Review of Resident #4's current FL2 dated 01/07/26 revealed there was an order for losartan (used to treat high blood pressure) 50mg one tablet every day hold if systolic blood pressure

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less than 100.

Review of Resident #4's February and March 2026 Medication Administration Record (MAR) revealed:
-There was a computer generated entry for losartan 50mg one tablet daily hold if systolic blood pressure below 100 scheduled at 8:00am.
-Losartan 50mg was documented as administered as ordered from 02/01/26-03/31/26.

Review of Resident #4's April 2026 MAR from 04/01/26-04/15/26 revealed:
-There was a computer generated entry for losartan 50mg one tablet daily hold if systolic blood pressure below 100 scheduled at 8:00am.
-Losartan 50mg was documented as administered as ordered from 04/01/26-04/15/26.

Review of Resident #4's Blood Pressure Log dated 02/25/26-03/28/26 revealed:
-Resident #4's blood pressure was documented daily as ordered.
-The blood pressure range from 02/25/26-03/28/26 was 120/78-170/76.

Review of Resident #4's Blood Pressure Log dated 03/29/26-04/15/26 revealed:
-Resident #4's blood pressure was documented daily as ordered.
-The blood pressure range for 03/29/26-04/15/26 was 122/70-140/80.

Interview with Resident #4 during the initial tour on 04/14/26 at 9:10am revealed:
-He was not receiving his blood pressure medication.
-He did not know the name of his blood pressure medication.
-The facility staff told him they reordered his

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blood pressure medication but it had not come in from the pharmacy.

Interview with the Resident Care Coordinator (RCC) on 04/15/26 at 9:47am revealed:
-There was no losartan 50mg tablets available for Resident #4.
-He had not administered Resident #4's losartan since Monday (04/13/26).
-He had reordered the losartan 50mg from the facility's contracted pharmacy that morning (04/15/26).

Observation of Resident #4's medications on hand on 04/15/26 at 9:55am revealed there was no losartan 50mg available on the medication cart.

Observation of a personal care aide (PCA) obtaining Resident #4 blood pressure on 04/15/26 at 10:20am revealed the blood pressure was 140/93.

Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 04/15/26 at 9:24am revealed:
-The pharmacy dispensed losartan 50mg 30 tablets (30-day supply) on 02/10/26, 02/26/26, and 03/16/26.
-They had received a request to refill the losartan 50mg today (04/15/26).

Telephone interview with a pharmacy technician from the facility contracted pharmacy on 04/15/26 at 4:22pm revealed:
-The facility had to order refills for all resident medications.
-There were barcode stickers on each bubble pack of medication.
-The facility staff had to pull the barcode reorder

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sticker from the medication pack, affix it to a refill order form, and fax it to the contracted facility pharmacy.
-The contracted facility pharmacy delivered once a day to the facility.
-Any refill request processed before 2:30pm would automatically go out in the daily delivery which would arrive at the facility between 7:00pm-8:00pm.
-If there was a medication that was urgently needed, a driver could be sent out and expedite the medication to the facility.

Telephone interview with Resident #4's PCP on 04/16/26 at 8:36am revealed:
-Losartan was ordered to manage Resident #4's high blood pressure.
-He depended on the RCC to communicate information about the resident needs to him.
-The facility did not notify him Resident #4's losartan was out.

Interview with the Administrator on 04/16/26 at 11:45am revealed:
-She and the RCC were responsible for contacting the PCP if a medication was not available for administration.
-She did not become aware Resident #4's losartan was not available until 04/15/26.

_____

The facility failed to follow-up to obtain foot and toenail care for Resident #2 resulting in pain in the resident's feet and the inability to wear shoes to protect his feet from being run over with the wheelchair and hitting objects with his feet. The facility failed to notify Resident #4's PCP there was no losartan 50mg available for administration. This was detrimental to the health, safety, and welfare and constituted a Type B Violation.

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| D 273 | Continued From page 20<br>The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/15/26 for this violation.<br><br>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 31, 2026. | D 273 | | |
| D 338 | 10A NCAC 13F .0909 Resident Rights<br><br>10A NCAC 13F .0909 Resident Rights<br>An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.<br><br>This Rule is not met as evidenced by:<br>TYPE B VIOLATION<br><br>Based on observations, interviews, and record review, the facility failed to treat 1 of 5 sampled residents (Resident #5) with dignity and respect related to Resident #5 sleeping on an air mattress on the floor and a toilet overflowing into her room on four occasions.<br><br>The findings are:<br><br>Review of Resident #5's current FL2 dated 01/07/26 revealed diagnoses included cervicalgia (stiffness of the cervical spine area), low back pain, and spondylosis lumbar region (age-related degeneration of the spinal column, often referred to as spinal arthritis).<br><br>Review of Resident #5's Resident Register revealed an admission date of 12/18/25. | D 338 | | |

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| D 338 | Continued From page 21<br><br>a. Interview with Resident #5 during the initial facility tour on 04/14/26 at 9:55am revealed:<br>-A common bathroom toilet outside her room overflowed into her room while she was sleeping in January or February 2026.<br>-The amount of water from the toilet into her room was "major".<br>-There was at least three inches of water in the floor of her room.<br>-She had been sleeping on an air mattress on the floor since the incident.<br>-The Housekeeper was trying to get a bed to put in the room for her.<br>-It was hard for her to get up and down off the bed in the floor.<br>-It would be "nice" to have a bed in her room.<br><br>Observation of Resident #5's bed on 04/15/26 at 2:58pm revealed there was a twin sized air mattress located on the floor as you entered the room.<br><br>Interview with Resident #5 on 04/15/26 at 2:58pm revealed:<br>-She had been sleeping on the air mattress in the floor of her room for at "least three months."<br>-If her back or legs were "acting up", she would sleep in her recliner or chair in her room instead.<br>-When she moved to her current room, facility staff offered her a bed and mattress that another resident had used.<br>-The mattress was covered in stains.<br>-The stains on the mattress looked like dried feces or blood.<br>-The former resident who had used the mattress before had a pet cat in the room.<br>-She was not sure if the stains on the mattress were from the resident or the cat.<br>-The bed frame was low to the ground. | D 338 | | |

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-It was hard to get up and down on.
-She told the facility staff the bed was too low for her.
-The facility did not have another bed frame or mattress.
-Instead they provided a platform king sized air mattress to put in the floor to sleep on, but it got a hole in it.
-She asked her family for help and they brought her a twin sized air mattress to sleep on in the floor.
-She had not said anything else about the bed and mattress to the facility staff because she just tries to get along.
-Her "depression" wore her out.
-Two times the toilet overflow water came into her room and was under the king sized air mattress she used.
-It was difficult to dry the king sized air mattress out after the overflow events.

Interview with the Administrator on 04/15/26 at 3:25pm revealed:
-Resident #5 moved to the room she was currently in "voluntarily."
-They told Resident #5 about the condition of the bed and mattress in the room and Resident #5 said it was what she wanted.
-Resident #5 told her the air mattress bed she had been using was "fine."
-She could get Resident #5 another bed.

Telephone interview with Resident #5's primary care provider (PCP) on 04/16/26 at 8:36am revealed:
-Resident #5 had not complained to him about back pain or trouble getting down to or up from her bed located on the floor of her room.
-Just because Resident #5 did not complain to him did not decrease the fact she needed a bed

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| D 338 | Continued From page 23<br>and a mattress to sleep on.<br><br>Interview with the Resident Care Coordinator (RCC) on 04/16/26 at 9:30am revealed:<br>-Resident #5's family member took the bed apart and moved it out of the room before Resident #5 moved into the room.<br>-The family member told him Resident #5 slept better on an air mattress.<br>-Resident #5 had been sleeping on the air mattress about a month.<br>-He had put the original bed in a vacant room in the facility.<br>-Resident #5 told him the original bed hurt her back.<br><br>Interview with the Administrator on 04/16/26 at 11:45am revealed:<br>-Resident #5 had a bed in the room and she had a family member take the bed out.<br>-Resident #5 told the RCC she would use an air mattress.<br>-Resident #5 said the original bed made her back hurt.<br>-She told the RCC Resident #5 needed a bed off the floor.<br>-She had noticed Resident #5's bed on the floor of the room on her monthly walk through of the facility.<br>-The RCC told her Resident #5 wanted to sleep on the air mattress on the floor.<br><br>b. Interview with Resident #5 during the initial facility tour on 04/14/26 at 9:55am and on 04/15/26 at 11:50am revealed:<br>-The toilet at the end of the left hallway from the living room overflowed into her bedroom.<br>-In January or February 2026, she was in her room sleeping and the toilet stopped up and was overflowing into her room. | D 338 | | |

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-There was at least three inches of water on her floor when it overflowed.
-She did not think there was feces in the overflow water that flooded her room, but she did not know for sure.
-The Maintenance staff had attempted to fix the toilet, but the flush valve was still not allowing enough water into the toilet reservoir to adequately flush the toilet.
-The toilet overflow problem was not as bad since the Maintenance staff replaced the flush valve a month ago.
-But the toilet had overflowed two times into her room since the flush valve was replaced.
-She kept a blanket down at the bottom of her door to keep the water out of her room.
-The toilet had overflowed into her room four times since she moved into the room.

Observation of the common bathroom at the end of the left hallway on 04/15/26 at 11:17am revealed:
-The toilet had human waste and paper in the toilet bowl.
-An attempted flush of the toilet would not provide enough water to flush the contents in the toilet bowl.

Interview with the Resident Care Coordinator (RCC) on 04/15/26 at 11:17am revealed:
-The toilet in the common bathroom at the end of the left hallway was not working "right."
-The toilet was used by all residents and staff.
-The Maintenance staff said he was going to replace the entire toilet to fix the problem.
-The new handle Maintenance staff put in the toilet was not strong enough to flush the toilet.
-The toilet had been difficult to flush for "a week or two."
-You had to flush the toilet three or four times

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|---|---|
| MCCULLOUGH'S REST HOME | 720 ORR'S CAMP ROAD HENDERSONVILLE, NC 28739 |

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| D 338 | Continued From page 25<br>before the toilet bowl contents would go down.<br><br>Interview with the Housekeeper on 04/15/26 at 11:29am and 11:48am revealed the toilet would overflow when the residents put too much paper into the toilet bowl and the paper would not go down.<br><br>Telephone interview with Maintenance staff on 04/15/26 at 11:45am revealed:<br>-The facility needed a new toilet installed in the left hallway common bathroom.<br>-The toilet overflowed a month ago.<br>-He put a new flush valve in the toilet a month ago so it would not overflow.<br><br>Interview with the RCC on 04/16/26 at 9:30am revealed:<br>-The toilet in the common bathroom at the end of the left hallway had not been flushing correctly for two weeks.<br>-The Maintenance staff told him they needed a new toilet.<br>-Resident #5 told him the toilet had overflowed into her room, and she and a family member cleaned it up.<br><br>Interview with the Administrator on 04/16/26 at 11:45am revealed:<br>-She did not know the toilet at the end of the left hallway was not working correctly.<br>-She did not know the toilet had overflowed into a resident room.<br><br>_____<br>The facility failed to provide a bed frame and mattress for Resident #5 requiring the resident to sleep on a twin sized air mattress on the floor which caused the resident pain in her back when getting up and down to the bed and failed to repair a toilet which overflowed into Resident #5's | D 338 | | |

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| D 338 | Continued From page 26<br>room and onto her belongings on four occasions requiring the resident to keep a blanket under the door to her room to keep toilet overflow out of her room. This was detrimental to health, safety, and welfare of the residents and constituted a Type B Violation.<br>_____<br>The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/15/26 for this violation.<br><br>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 31, 2026. | D 338 | | |
| D 358 | 10A NCAC 13F .1004 (a) Medication Administration<br><br>10A NCAC 13F .1004 Medication Administration<br>(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:<br>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and<br>(2) rules in this Section and the facility's policies and procedures.<br><br>This Rule is not met as evidenced by:<br>FOLLOW-UP TO TYPE A1 VIOLATION.<br><br>Based on these findings, the previous Type A1 Violation was not abated.<br><br>Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 4 sampled residents (Resident #4) related to a medication | D 358 | | |

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used to treat high blood pressure.

The findings are:

Review of Resident #4's current FL2 dated 01/07/26 revealed:
-Diagnoses included schizophrenia.
-There was an order for losartan (used to treat high blood pressure) 50mg one tablet every day hold if systolic blood pressure less than 100.

Review of Resident #4's February and March 2026 Medication Administration Record (MAR) revealed:
-There was a computer generated entry for losartan 50mg one tablet daily hold if systolic blood pressure below 100 scheduled at 8:00am.
-Losartan 50mg was documented as administered as ordered from 02/01/26-03/31/26.

Review of Resident #4's April 2026 MAR from 04/01/26-04/15/26 revealed:
-There was a computer generated entry for losartan 50mg one tablet daily hold if systolic blood pressure below 100 scheduled at 8:00am.
-Losartan 50mg was documented as administered as ordered from 04/01/26-04/15/26.

Review of Resident #4's Blood Pressure Log dated 02/25/26-03/28/26 revealed:
-Resident #4's blood pressure was documented daily as ordered.
-The blood pressure range from 02/25/26-03/28/26 was 120/78-170/76.

Review of Resident #4's Blood Pressure Log dated 03/29/26-04/15/26 revealed:
-Resident #4's blood pressure was documented daily as ordered.
-The blood pressure range for 03/29/26-04/15/26

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| D 358 | Continued From page 28<br>was 122/70-140/80.<br><br>Interview with Resident #4 during the initial tour on 04/14/26 at 9:10am revealed:<br>-He was not receiving his blood pressure medication.<br>-He did not know the name of his blood pressure medication.<br>-The facility staff told him they reordered his blood pressure medication but it had not come in from the pharmacy.<br><br>Interview with the Resident Care Coordinator (RCC) on 04/15/26 at 9:47am revealed:<br>-There was no losartan 50mg tablets available for Resident #4.<br>-He had not administered Resident #4's losartan since Monday (04/13/26).<br>-He had reordered the losartan 50mg from the facility's contracted pharmacy that morning (04/15/26).<br>-The facility's contracted pharmacy was going to send Resident #4's losartan on the evening delivery.<br>-He did not know why Resident #4 was out of the losartan 50mg.<br>-He could not find the empty pharmacy bubble pack for Resident #4's losartan 50mg tablets.<br><br>Observation of Resident #4's medications on hand on 04/15/26 at 9:55am revealed:<br>-There was no losartan 50mg available on the medication cart.<br>-There was no empty pharmacy bubble pack available for Resident #4's losartan 50mg tablets.<br><br>Observation of a volunteer obtaining Resident #4 blood pressure on 04/15/26 at 10:20am revealed the blood pressure was 140/93. | D 358 | | |

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Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 04/15/26 at 9:24am revealed:
-The pharmacy dispensed losartan 50mg 30 tablets (a 30-day supply) on 02/10/26, 02/26/26, and 03/16/26.
-They had received a request to refill the losartan 50mg "today" (04/15/26).

Interview with the RCC on 04/15/26 at 10:10am revealed:
-He did not keep pharmacy delivery sheets.
-Copies of the delivery sheets would have to be obtained from the facility's contracted pharmacy.

Telephone interview with a pharmacy technician from the facility contracted pharmacy on 04/15/26 at 4:22pm revealed:
-The facility had to order refills for all resident medications.
-There were barcode stickers on each bubble pack of medication.
-The facility staff had to pull the barcode reorder sticker from the medication pack, affix it to a refill order form, and fax it to the contracted facility pharmacy.
-The contracted facility pharmacy delivered once a day to the facility.
-Any refill request processed before 2:30pm would automatically go out in the daily delivery which would arrive at the facility between 7:00pm-8:00pm.
-If there was a medication that was urgently needed, a driver could be sent out and expedite the medication to the facility.

Telephone interview with Resident #4's primary care provider (PCP) on 04/16/26 at 8:36am revealed:
-Losartan was ordered to manage Resident #4's

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high blood pressure.
-He was surprised the facility had run out of the losartan.
-He depended on the RCC to communicate information about the resident needs to him.
-The facility did not notify him Resident #4's losartan was out.
-"Usually" the facility staff let him know if they needed a refill on a medication.
-He could reorder medications by escribing the facility's contracted pharmacy or call the pharmacy to reorder a medication.
-He was available by phone 24 hours a day 7 days a week.
-He was always available when they needed him.
-Not receiving losartan 50mg for a week put Resident #4 at risk for high blood pressure, chest pain, dizziness, and headaches.
-Severe high blood pressure could put Resident #4 at risk for heart attack and stroke.

Interview with the RCC on 04/16/26 at 9:30am revealed:
-He called the contracted facility pharmacy on 04/15/26 to get a refill on Resident #4's losartan 50mg.
-The pharmacy sent the losartan on the evening of 04/15/26.
-The weekend MA told him on Monday (04/13/26) to call the pharmacy about refilling Resident #4's medication.
-Reordering the medication "slipped by" him.
-He must have forgotten to call the contracted facility pharmacy to reorder the losartan 50mg.
-To reorder medications for the residents he pulled the reorder sticker from the top of the bubble pack and affixed it to the refill order sheet and faxed it to the pharmacy.
-If the pharmacy did not send the medication on the next delivery, he would call the pharmacy to

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see why it did not come in on the delivery.
-When Resident #4 asked him where his blood pressure medication was, he told him not to worry that he would get it.
-He told Resident #4 he was waiting on the facility's contracted pharmacy to deliver the losartan.
-Resident #4's MAR was inaccurate where he signed, he administered losartan on 04/13/26, 04/14/26, and 04/15/26.
-His vision was bad and he would sign the MAR without thinking about it.

Interview with the Administrator on 04/16/26 at 11:45am revealed:
-She would have caught that Resident #4's losartan was not available if she had been doing medication cart audits.
-Her last medication cart audit was a couple months ago.
-She did not know the Resident #4's losartan was not available for administration until 04/15/26.
-The weekend MA or the RCC should have called the facility's contracted pharmacy immediately to get the losartan delivered as quickly as possible.
-The pharmacy would deliver any day.
-The PCP was always available to send prescriptions to the facility's contracted pharmacy when needed.

Attempted interview on 04/16/26 at 8:30am with the medication aide (MA) who administered medications on 04/11/26 and 04/12/26 was unsuccessful by exit.

_____

The facility failed to administer Resident #4's losartan for a week which put Resident #4 at risk of high blood pressure, chest pain, dizziness, headaches, and severe high blood pressure which could increase Resident #4's risk of a heart

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| D 358 | Continued From page 32<br>attack or stroke. This failure was serious neglect and constituted a Type A1 Violation.<br>_____<br>The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/16/26 for this violation. | D 358 | | |
| D 438 | 10A NCAC 13F .1205 Health Care Personnel Registry<br><br>10A NCAC 13F .1205 Health Care Personnel Registry<br>The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record reviews, the facility failed to ensure the 24-hour initial reports and/or 5-day investigative reports for the health care personnel registry (HCPR) were completed as required and in a timely manner related to an allegation of abuse by 1 of 1 staff member.<br><br>The findings are:<br><br>Review of Resident #1's current FL2 dated 02/26/26 revealed:<br>-Diagnoses included coronary artery disease, diabetes mellitus, hypertension, and dementia.<br>-He was semi-ambulatory.<br>-He required assistance with bathing, feeding and dressing.<br><br>Review of Resident #1's Resident Register revealed an admission date of 10/22/25. | D 438 | | |

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| D 438 | Continued From page 33<br><br>Review of Resident #1's care plan dated 02/10/26 revealed:<br>-He had a history of wandering behaviors.<br>-He had a history of verbally and physically abusive behaviors.<br>-He had a history of resisting care.<br>-He was homicidal.<br>-He had a history of self-injury.<br>-He had a history of mental illness and developmental disabilities.<br><br>Interview with Resident #1 on 04/14/26 at 8:55am revealed:<br>-He was in an altercation with the Resident Care Coordinator (RCC) approximately 2 or 3 months ago.<br>-He was upset when staff refused to feed his dog.<br>-He slammed the dog bowl on the counter at the kitchen area.<br>-RCC picked him up and pulled him over the counter then was thrown down to the floor.<br>-He thought his hip was fractured.<br>-He was not sure if there were any witnesses.<br>-He went to the hospital that evening.<br><br>Interview with the Resident Care Coordinator on 04/14/26 at 2:42pm revealed:<br>-He knew Resident #1 fell in March 2026.<br>-Resident #1 came to the kitchen area with a dog bowl.<br>-Resident #1 was not satisfied with the brand of dog food that was available.<br>-RCC was holding the dog bowl and Resident #1 grabbed and pulled the bowl and fell backwards to the floor.<br>-Resident #1 crawled back to his room claiming he was hurt.<br>-Emergency medical services (EMS) were called but Resident #1 refused treatment. | D 438 | | |

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| D 438 | Continued From page 34<br>-He knew Resident #1 was taken to the hospital the next day for hip pain.<br>-He is not sure if Resident #1's hip pain was a result of the fall from the previous day.<br>-He did not complete an incident report or document the fall in the facility logbook.<br>-He informed Resident #1's guardian of the fall but doesn't remember the date.<br><br>Interview with Resident #1's Guardian on 04/14/26 at 3:19pm revealed:<br>-He receives notifications of incidents from the facility.<br>-He was notified by facility staff that Resident #1 had a fall.<br>-He knew Resident #1 refused EMS treatment initially but later decided to go to the hospital for hip pain.<br>-He knew Resident #1 did not have a broken hip and had a history of osteonecrosis in his hip (death of bone tissue due to interupted blood supply).<br>-He did not have concerns with the care Resident 1 is receiving at the facility.<br>-He did not receive any complaints or allegations from Resident #1 regarding staff or other residents pushing him.<br>-He did not feel staff would push a fragile person.<br>-He was aware Resident #1 has a history of anger and dementia related behaviors.<br><br>Interview with a personal care aide (PCA) on 04/14/26 at 3:58pm revealed:<br>-He was aware of Resident #1's fall.<br>-He was not working during the incident and worked the night shift after the incident.<br>-He did not notice any injuries on Resident #1.<br>-Resident #1 will not talk to him.<br>-Resident #1 has a history of anger and he often gets upset easily. | D 438 | | |

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| D 438 | Continued From page 35<br>-He did not remember the date of the incident.<br><br>Interview with the Administrator on 04/14/26 at 3:38pm revealed:<br>-She was aware that Resident #1 fell in March 2026.<br>-She was not working the day that Resident #1 fell.<br>-RCC is responsible for the facility when she is not there.<br>-She knew Resident #1 refused medical care after the incident and went to the hospital the next day.<br>-She did not know how Resident #1 obtained the hip injury in March 2026.<br>-She did not know the date of the incident.<br>-She expects staff to document incidents with residents in the facility logbook.<br>-She notified Resident #1's guardian.<br>-She did not complete an accident and incident report.<br>-She is responsible for completing accident and incident reports.<br>-She doesn't complete an incident report if the incident was reported to the Department of Social Services.<br>-She did not know she had to report injuries of unknown origin to the Health Care Personnel Registry (HCPR).<br>-She did not report Resident #1's injuries of unknown origin in March 2026 within 24 hours to the (HCPR) because she did not know they had to be reported.<br><br>Telephone interview with the medication aide on 04/14/26 at 3:59pm was unsuccessful. | D 438 | | |