STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 survey and complaint investigation on February 24, 2025 to February 27, 2025.	D 000		
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the hot water temperatures were maintained at a minimum of 100 degrees Fahrenheit (°F) to a maximum of 116°F for 7 of 17 sampled fixtures with hot water temperatures ranging from 52 degrees F to 125.2 degrees F. The findings are: Review of the facility's current license effective 01/01/25 revealed the facility was licensed with a capacity of 163 beds. Review of the facility's census reports provided on 02/24/25 revealed the facility's in-house census was 61 residents. Observation of the bathroom in resident room 29	D 113	The hot water pump was replaced with a new pump to ensure temperatures were at the appropriate ranges. The Maintenance Director/Lead Housekeeper received Training on the correct way to check water temperatures. The training included: (1) how to calibrate the thermometer;(2) required water temperature ranges; (3) proper way to check the water temperature using the calibrated thermometer; (4) proper documentation of water temperature checks(location and fixture); and measures to take when the water temperatures are below or above the required water temperature ranges. Implementation of revised water temperature check form that includes;(1) the required water temperatures (minimum of 100 degrees F not to exceed 116 degrees F); (2) date; (3) the specific location within the facility; and (4) the fixture that was checked.	2/25/2025 2/27/2025 3/21/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Erica Owen — TITLE: Administrator — (X6) DATE: 4-4-25

Reviewed and acknowledged 04/10/25 KC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 113	Continued From page 1 on C hall on 02/24/25 at 10:00am revealed the hot water temperature at the sink was 125.2 degrees Fahrenheit (°F). Observation of the shower room located on B hall, to the right of resident room 20 revealed: -The hot water temperature at the sink was 118.8°F. -The hot water temperature at the tub was 120.9°F. Interview with a resident in room 29 on 02/24/25 at 10:00am revealed: -Sometimes the water was hot and other times the water was cold. -The water had never been too hot or too cold. -He had never been burned by the hot water. Interview with another resident on 02/27/25 at 8:47am revealed: -She used all the shower rooms on B hall. -Sometimes she turned the water on for herself and other times staff turned the water on for her. -The water had never been too hot. -She had never been burned by the hot water. -The water was usually warm but kind of cold sometimes. -She told staff when the water was kind of cold and they added hot water to make the water warmer. Interviews with a personal care aide (PCA) on 02/27/25 at 8:16am and 12:00pm revealed: -PCAs rotated halls every 1 to 2 days. -She last worked B hall 3 days ago. -None of the residents complained about the water temperatures on B hall. Observations of re-check of water temperature in resident room 29 on 02/24/25 at 4:37pm revealed	D 113	**Monitoring System** The Maintenance Director/Lead Housekeeper shall continue weekly water checks and at other times as deemed necessary by incorrect water temperature checks. The Maintenance Director/Lead Housekeeper shall document all water temperature checks using the revised water temperature log; and, shall document all follow up to water temperatures that were below or above the required water temperatures. The Administrator shall review the water temperature logs weekly and initial as such, to verify correct water temperature checks are followed and documented as such x 90 days, and then monthly thereafter.	2/26/2025 3/21/2025 3/21/202

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 113	Continued From page 2 the hot water temperature at the sink was 100.6°F. Observations of re-check of water temperatures in the shower room located on B hall, to the right of resident room 20 revealed: -The hot water temperature at the sink was 112.6°F. -The hot water temperature at the tub was 112.6°F and dropped to 111°F. Observation of the shared bathroom for resident room 47 and resident room 49 on F hall on 02/24/25 at 10:10am revealed: -The hot water temperature at the sink was 52°F. -The temperature of the hot water was the same as the temperature of the cold water at the sink. Interview with a resident residing in room 47 on F hall on 02/24/25 at 10:10am revealed: -There was no hot water at the sink. -It had been that way for about 3 months. -She reported it to staff, but she could not recall which staff or when she reported it. Interview with a resident residing in room 49 on F hall on 02/24/25 at 10:13am revealed: -The water in her bathroom did not get warm. -There was no hot water. -It had been that way for several days. Observation of the common bathroom across the hall from the library on F hall on 02/24/25 at 10:16am revealed: -The hot water temperature at the bathroom sink was 56 °F. -The hot water temperature at the tub was 62 °F. -The hot water temperature at the shower was 68 °F.	D 113		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 113	Continued From page 3 Interview with Maintenance / Lead Housekeeper on 02/24/5 at 10:28am revealed: -The hot water in the facility's common bathrooms was sometimes not warm in the morning after residents had taken morning showers. -He was not aware of any current problems with the hot water temperatures in the facility. -He would go check the hot water heater. -He did not answer when asked how many hot water heaters were in the facility. Second interview with Maintenance / Lead Housekeeper on 02/24/5 at 11:18am revealed: -He checked the facility's water temperature every week. -He usually let the hot water run until it reached 110°F and then turned it off because if there were issues with the water temperature, it was usually too cold, not too hot. -He documented the weekly checks on a log. Review of the facility's Weekly Water Temperature Logs for November 2024 - February 2025 revealed: -Each temperature log had rows for weeks 1 -5 and columns for A - G halls. -There was one hot water temperature for each hall documented each week. -The log did not specify what room or the type of water fixture (such as sink, tub, or shower) was checked. -There was a computer printed range of 110 - 115°F printed in the upper right corner of each temperature log. -All temperatures documented each week for all halls for November 2024 through February 2025 (week 3) were 110°F. Interview with the Administrator on 02/24/25 at 2:53pm revealed:	D 113		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 113	Continued From page 4 -She thought the hot water temperature should be between 110°F - 116°F. -The Maintenance / Lead Housekeeper just told her today, 02/24/25, that when he checked water temperatures, he stopped once the thermometer was on 110°F. -She would instruct him to check the water temperature until it stopped increasing on the thermometer to make sure he was identifying any temperatures that were too hot. -There were multiple hot water heaters because it was a large facility. -A resident in room 49 complained about the water being cold in her bathroom last week (could not recall exact date). -The water was checked in that resident's room last week and the water temperature had warmed up and was in the correct range. -She contacted a plumber to come to the facility today, 02/24/25. Second interview with the Administrator on 02/24/25 at 4:30pm revealed: -A plumber had just left the facility after checking the hot water. -They were unable to get any hot water at the sink in the shared bathroom for resident room 47 and resident room 49. -The plumber thought a pump on the hot water heater needed replacing so the plumber was going to order the part. -She contacted the facility's owner and the owner wanted to contact a second plumber who would come to the facility tomorrow, 02/25/25. -The Maintenance / Lead Housekeeper adjusted the thermostat on the hot water heater, and she thought that had corrected the hot water temperatures on B hall. Second observation of the common bathroom	D 113		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 113	Continued From page 5	D 113		

across the hall from the library on F hall on 02/24/25 at 4:34pm revealed:
-The hot water temperature at the bathroom sink was 102 °F.
-The hot water temperature at the tub was 64 °F.
-The hot water temperature at the shower was 66 °F.

Second observation of the shared bathroom for resident room 47 and resident room 49 on F hall on 02/24/25 at 4:45pm revealed the hot water temperature at the sink was 56 °F.

Interview with the second plumber on 02/25/25 at 12:18pm revealed:
-There were 6 or 7 hot water heaters in the facility.
-The pump on one of the hot water heaters (for F hall) was not working properly and he could get it replaced today, 02/25/25.

Third interview with the Administrator on 02/25/25 at 2:53pm revealed a second plumber had repaired the pump for the hot water heater for the F hall.

Third observation of the common bathroom across the hall from the library on the F hall on 02/25/25 at 4:23pm revealed:
-The hot water temperature at the bathroom sink was 140°F with steam.
-The hot water temperature at the tub was 108 °F but dropped rapidly within a few seconds to 58°F.
-The hot water temperature at the shower was 80 °F but dropped rapidly within a few seconds to 62°F.

Third observation of the shared bathroom for resident room 47 and resident room 49 on F hall on 02/25/25 at 4:35pm revealed the hot water

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 113	Continued From page 6	D 113		

temperature at the sink was 56 °F.

Fourth interview with the Administrator on 02/25/25 at 4:35pm revealed:
-She was not sure if the facility's Maintenance / Lead Housekeeper had re-checked the hot water temperatures since the second plumber had completed repairs.
-She would contact the second plumber and have him come back to the facility.

Interview with a medication aide / personal care aide (MA/PCA) on 02/26/25 at 10:00am revealed:
-She had heard residents complain about the water not being warm/hot in the common bathroom near the library on F hall over the last few months.
-The Maintenance / Lead Housekeeper adjusted the hot water heater and it would get better but then it would start being cold again.
-She used different shower rooms on other halls to bathe residents mostly because the room temperature was warmer in the other shower rooms.

Recheck of the common bathroom across the hall from the library on the F hall on 02/26/25 at 8:22am with the Maintenance / Lead Housekeeper revealed:
-The hot water temperature at the sink and shower was 108°F.
-The hot water temperature at the tub was 112°F.
-The Maintenance / Lead Housekeeper checked the hot water with his thermometer and it was 111°F at the sink, 110°F at the shower, and 114°F at the tub.

Third interview with the Maintenance / Lead Housekeeper on 02/26/25 at 8:27am revealed:
-He had turned down the thermostat on the hot

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 113	Continued From page 7 water heater for the F hall last night. -The water temperatures were back in the correct range today, 02/26/25. Fourth interview with the Maintenance / Lead Housekeeper on 02/26/25 at 10:15am revealed: -He checked the water temperature on each hall each week. -He checked the tub, showers and sinks in each shower room on B, C, E, and F Halls, and two resident rooms on A and D Halls. -He was not aware the required hot water temperature was 100°F - 116°F. -He thought the correct range was 110°F - 116°F because that was the range printed at the top of the water temperature logs. -He gave a copy of the hot water temperature logs to the Administrator each week.	D 113	The staff member was removed from the medication cart until verification of completing the 15 hour Medication Aide Course was obtained.	2/26/2025
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 4 sampled staff (C) who administered medications completed the	D 125	Staff C had completed the Adult Care Home Medication Aide 15- hour course at a previous employing adult care home. The staff member was able to obtain the certificate and the certificate was placed in his file. All Medication Aide training records were reviewed to make sure they met the qualifications of a medication aide in an adult care home per 10A NCAC 13F. 0403(a).	3/82025 2/27/25 & 3/20/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 125	Continued From page 8 state approved 5, 10, or 15-hour medication aide training course. The findings are: Review of Staff C's personnel record revealed: -Staff C was hired as a medication aide (MA) on 04/23/24. -Staff C completed the medication administration clinical skills validation checklist on 05/15/24. -Staff C passed the state-approved MA written exam on 12/05/07. -There was no documentation of Staff C completing the state-approved 5, 10, or 15-hour MA training courses. Review of residents' December 2024 - February 2025 medication administration records (MARs) revealed: -Staff C documented administering medications on 14 days in December 2024 including 12/07/24, 12/08/24, 12/10/24, 12/11/24, 12/16/24, 12/19/24, 12/20/24 - 12/22/24, 12/26/24, and 12/28/24 - 12/31/24. -Staff C documented administering medications on 20 days in January 2025 including 01/01/25, 01/05/25, 01/06/25, 01/08/25 - 01/13/25, 01/16/25 - 01/20/25, 01/22/25, and 01/27/25 - 01/31/25. -Staff C documented administering medications on 14 days in February 2025 including 02/01/25, 02/03/25 - 02/05/25, 02/09/25 - 02/11/25, 02/13/25 - 02/15/25, 02/21/25, and 02/23/25 - 02/25/25. Telephone interview with Staff C on 02/27/25 at 5:20pm revealed: -He had completed some online MA classes. -He had not completed the 5, 10, or 15-hour state-approved MA training courses. -He was not aware he needed to complete the	D 125	Administrator received training by an Adult Care Home Consultant on the qualifications of a medication aide per 10A NCAC 13F. 0403(a), and implementation of verification system of the qualifications. **Monitoring System** Implementation of new hire checklist to include the qualifications of a medication aide per 10A NCAC 13F .0403(a). Administrator shall ensure by using the new hire checklist that all medication aide qualifications are met before the staff member is hired and scheduled as a medication aide. Adult Care Home Consultant shall randomly monitor medication aides qualifications monthly x 90 days. Administrator shall monitor medication aides qualifications every 90 days. Any staff members identified as not meeting the medication aide qualifications shall be removed from the schedule until the qualification is completed.	3/27/2025 3/27/2025 3/27/2025 3/27/2025 4/1/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 125	Continued From page 9 state-approved MA training courses. Interview with the Business Office Manager (BOM) on 02/27/25 at 5:28pm revealed: -Staff C had completed an online 5 and 10-hour MA class provided by the facility's contracted pharmacy. -The online classes were completed by staff independently on a computer with no on-site instructor and no skills check offs. -She thought the MAs could use the online 5 and 10-hour MA class provided by the pharmacy in place of the state-approved 5, 10, and 15-hour MA training course. Interview with the Administrator on 02/27/25 at 5:28pm revealed: -She and the BOM were responsible for making sure the MAs had the required training and qualifications. -She thought the 5 and 10-hour online MA class provided by the facility's contracted pharmacy was sufficient. -She did not realize the MAs were required to use the state-approved 5, 10, or 15-hour MA training courses.	D 125		
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 B VIOLATION	D 273	Tubing was obtained for Resident #1 Clarification of order for portable oxygen tank for resident #3 and noncompliance of resident #3 was obtained from the pcp and orders implemented. Records Reviewed for health care follow up on residents.	2/24/2025 3/20/2025 2/27/2025 3/31/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 10 Based on observations, interviews, and record reviews, the facility failed to ensure health care coordination for 2 of 5 sampled residents (#1, #3) related to ensuring the tubing was in place for an oxygen concentrator after a hospital discharge (#1), failing to obtain portable oxygen and notify the primary care provider of non-compliance with using the correct oxygen concentration as ordered (#3), and failing to ensure a resident with a left foot injury was seen for a follow-up appointment with the podiatrist (#3). The findings are: 1. Review of Resident #1's FL-2 dated 11/01/24 revealed: -Diagnoses included chronic obstructive pulmonary disease (COPD), history of cerebrovascular accident (CVA) and type 2 diabetes. -The resident was documented as semi-ambulatory. -The resident required assistance with bathing and dressing. -There was an order for 2 liters of oxygen continuous at bedtime. Review of Resident #1's assessment and care plan dated 11/01/24 revealed: -The resident was documented as ambulatory with aide or device with limited strength and needed a wheelchair. -The resident required oxygen at night. -The resident was sometimes disoriented, forgetful and needed reminders. Review of an after visit summary (AVS) from Resident #1's 02/15/25-02/18/25 hospitalization revealed Resident #1 was diagnosed with pneumonia due to infectious organism.	D 273	Administrator,RCC, SIC/MA received training on 10 A NCAC 13F.0902(b). by and Adult Care Home Consultant Implementation of a Health Care referral and follow up documentation sheet. Implementation of a Health Care referral and follow up binder. Established roles and responsibilities for ensuring health care referral and follow up is completed as ordered by a resident's provider or other persons involved in the care of the resident. Trained staff responsible for health care referral and follow on the established documentation form and the facilities revised policy on assuring referral and follow up to meet the routine and acute health care needs of the residents.	3/6/2025 2/27/2025 2/27/2025 3/6/2025 3/6/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 11 Review of facility progress notes revealed: -Resident #1 went to the hospital after falling on 02/14/25. -Resident #1 returned to the facility from the hospital on 02/18/25. Review of a progress note from a hospice Registered Nurse (RN) dated 02/22/25 revealed: -The visit was a follow-up for admission. -Fine crackles were heard in upper lobes bilateral and diminished in lower lobes bilateral. (Crackles indicate there might be fluid inside of the lungs or the lungs are not inflating properly.) -Durable medical equipment (DME) was to be looked into due to switching of hospice agencies. Review of a Client Coordination Note Report from Resident #1's hospice agency dated 02/27/25 revealed: -On 02/18/25, they were notified by the Resident Care Coordinator (RCC) that Resident #1 needed tubing for his oxygen concentrator. -The hospice agency's Administrative Assistant took 3 nasal cannula tubes out to the facility to see if that was what was needed. -After delivery of those items, it was indicated that additional tubing was needed other than what was brought. -The DME company was notified and a ticket was created to have a DME representative take the needed tubing. Observations of Resident #1's room on 02/24/25 at 11:09am and 4:43pm revealed: -There was a sign on the door stating oxygen was in use in the room. -Resident #1 had an oxygen concentrator and portable oxygen tank in the room.	D 273	Administrator and Resident Care Coordinator(RCC) received training by an Adult Care Home Consultant on the necessary steps for and establishing systems to assure health care referral and follow up is completed as ordered and in a timely manner. Training included immediate review of all referrals and follow up, importance of reviewing all documentation received from hospitalization, hospice/home health agencies, primary care providers or other providers involved in the care of a resident. Adult Care Home Consultant revised policy and procedures on health care referral and follow up to assure established roles and responsibilities are clear. Administrator and RCC were trained on the revised policy and established health are referral and follow up systems. **Monitoring Systems** Implementation of Health Care Referral and Follow Up Tracking Form. Adult Care Home Consultant shall randomly audit 10% of resident records monthly x 90 days to assure healthcare Follow up.	3/6/2025 3/13/2025 3/20/2025 3/27/2025 3/27/2025 2/27/2025 3/23/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 12 Interview with Resident #1 on 02/24/25 at 11:09am and 4:43pm revealed: -He suffered from COPD. -He was in the hospital last week for pneumonia. -He had not been able to use the oxygen since he returned from the hospital. -He had not been able to use the oxygen since last Wednesday night (02/19/25) due to missing tubing. -Facility staff and hospice were working to obtain the tubing for the oxygen concentrator. -He had no issues breathing at night without the oxygen. -He did not sleep as well without the oxygen. -He woke up in the morning congested when he did not use oxygen at night. -The fluid from the COPD did not build up as fast when he had the oxygen at night. -The oxygen was working prior to his admission to the hospital. -When he returned from the hospital, one of the tubes was missing that went to the oxygen concentrator. -He told the medication aide (MA) and RCC Wednesday (02/19/25) when he returned that the tube was missing. -He was told 2 or 3 times by facility staff that they were working on obtaining the tubing needed for the oxygen concentrator. -The tubing was brought to him today (02/24/25) and the oxygen concentrator was working. -The new hospice agency delivered a new oxygen concentrator today (02/24/25). Second interview with Resident #1 on 02/27/25 at 10:38am revealed: -When he returned from the hospital, all the tubing for the oxygen concentrator was missing. -When the tubing was provided, the short piece that went from the water bottle to the front was	D 273	Administrator daily meetings (M-F) for communication to assure procedures are being followed and are understood, to discuss health care referrals and necessary steps for follow up(reviewing tracking form). Adult Care Home Consultant shall monitor health care referral and follow up procedures to assure they are being followed and revise as necessary x 90 days and then upon request thereafter. Administrator/RCC shall audit 10% of resident records monthly x 90 days then quarterly thereafter to assure healthcare referral and follow up. Med aides shall monitor and document as such that oxygen tubing is in place and working properly daily and upon each administration time. RCC shall monitor and document as such that oxygen tubing is in place and working properly weekly and to assure staff are following proper procedures	3/12/2025 3/12/205 3/31/2025 3/20/2025 3/20/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 13	D 273		

missing so the oxygen was not blowing.
-He did not know the short piece was missing until the hospice nurse told him that same day, the day that he received the big tube.
-He had the portable oxygen tank in his room for about 1 year but never used it and did not know how to use it.
-He had not been shown how to use the portable oxygen.
-He was not offered portable oxygen during the time he was without the tubing for the oxygen concentrator.
-He did not wear the oxygen for 4 days because it was not blowing.
-The facility got the correct tubing the day before he got the equipment from the new hospice agency.

Interview with a personal care aide (PCA) on 02/26/25 at 8:55am revealed:
-PCAs rotated hall assignments daily.
-She worked with Resident #1 when she was rotated to his hall.
-She made sure he got up for breakfast and assisted him with getting up, if needed.
-She was not working on his hall today (02/26/25).
-Resident #1 recently went to the hospital but she did not know why.
-He was not on oxygen prior to going to the hospital that she had noticed.
-He was on oxygen when he returned from the hospital.
-Resident #1's oxygen was working when he returned from the hospital.
-She was not aware of any issues with his oxygen concentrator.

Interview with a 2nd PCA on 02/27/25 at 8:16am revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 14	D 273		

-She worked 6:00am to 2:00pm.
-PCAs rotated halls every 1 to 2 days.
-She last worked on Resident #1's hall last week, a day or 2 after he returned from the hospital.
-Resident #1 used oxygen prior to going to the hospital.
-Resident #1 could be stubborn about using the oxygen and would say he did not need it.
-Staff redirected Resident #1 to put the oxygen on.
-She did not recall if she worked the day Resident #1 returned from the hospital.
-She did not work evenings so she did not know if Resident #1 wore the oxygen at night.

Interview with a 3rd PCA on 02/27/25 at 5:40pm revealed:
-She did not work on Resident #1's hall from 02/18/25 to 02/24/25.
-She worked with Resident #1 on occasion and was working his hall today (02/27/25).
-Resident #1 was diagnosed with pneumonia while in the hospital.
-She was not aware of any issues with his oxygen when he returned from the hospital.
-She had seen Resident #1 sleeping with oxygen on but some nights he took it off.

Interview with a 4th PCA on 02/27/25 at 5:50pm revealed:
-She worked on Resident #1's hall from 02/20/25 to 02/24/25.
-Resident #1 was in bed right after dinner.
-Sometimes he had the oxygen on and other times he did not; specific dates and times were unknown, and she did not know if he had the oxygen on at 8:00pm.
-She went in to check to see if he was breathing, asked if he needed anything and took out the trash.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 15	D 273		

-Resident #1 did not complain about issues with the oxygen concentrator or tubing.
-The MA documented whether the resident was wearing oxygen or not.

Interview with a medication aide (MA) on 02/27/25 at 5:21pm revealed:
-Resident #1's oxygen was put on him every night, but he took it off to go smoke.
-MAs went back to check to make sure Resident #1 had the oxygen on.
-Resident #1 was not used to wearing oxygen at night but had gotten in the routine of wearing oxygen at night.
-Resident #1 said the tubing was bad on the oxygen concentrator in the past but she could still feel the oxygen coming through the tube.
-Resident #1 wanted the oxygen to be forceful when coming through the tube so they had to put the pulse oximeter on him so he could see his oxygen saturation.
-She was not aware of Resident #1 complaining about missing tubing after his return from the hospital.
-She did not work with Resident #1 from 02/18/25 to 02/23/25.

Interview with the RCC on 02/24/25 at 12:20pm revealed:
-Resident #1 went to the hospital after a fall on 02/14/25 and returned last Tuesday (02/18/25).
-She found out on Wednesday (02/19/25) that Resident #1 was missing tubing for the oxygen concentrator.
-She called the hospice agency on Wednesday (02/19/25) to request tubing for Resident #1's oxygen concentrator.
-The hospice agency came out Wednesday (02/19/25) and was supposed to return with tubing for the oxygen concentrator; but never

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 16	D 273		

returned.
-She found out on Wednesday (02/19/25) that the hospice agency was not going to continue providing services to Resident #1 due to insurance issues.
-A new hospice agency admitted Resident #2 for services on Friday (02/21/25).

Second interview with the RCC on 02/26/25 at 10:12am revealed:
-When Resident #1 returned from the hospital, the tubing that went from the oxygen concentrator to the part that holds the water, as well as the long tubing with the nasal cannula, was gone.
-She was not informed that the oxygen concentrator tubing was missing until the day after Resident #1 returned from the hospital.
-She called the previous hospice agency to get the tubing.
-The previous hospice agency brought the nasal cannula piece later that day but the piece that went to the water tank was still missing.
-Later that day the hospice agency told her she could bypass the water and just use oxygen.
-She was unaware that the oxygen concentrator could still be used without the water tank tubing.
-Resident #1 went one night without the oxygen.
-She told Resident #1 he could still use oxygen without the water tank tubing.
-She was not aware Resident #1 was without oxygen for 5 nights.

Third interview with the RCC on 02/27/25 at 9:00am revealed:
-She found out the day after (that next morning) Resident #1 returned from the hospital that all of the tubing for the oxygen concentrator was missing.
-She called the previous hospice agency for tubing, and they only brought the tubing that went

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 17	D 273		

from the water bottle to the nasal canula.
-She plugged the tubing directly into the concentrator that same day because the hospice agency told her to.
-She was not aware of any other issues with the concentrator.
-Resident #1 was admitted to a new hospice agency on Saturday (02/15/25).
-On Monday (02/24/25), when the Surveyor told her Resident #1 was having issues with the concentrator, she called the new hospice agency and asked for his new equipment.

Interview with the Administrator on 02/24/25 at 11:41am revealed:
-She was not aware Resident #1 had issues with his oxygen concentrator.
-She was not aware Resident #1 had been without oxygen at night since returning from the hospital.
-She would check to see what was wrong with Resident #1's oxygen.

Second interview with the Administrator on 02/26/25 at 11:14am revealed:
-Resident #1 had a fall last week and was sent to the hospital.
-She was not in the building when Resident #1 went to the hospital.
-Resident #1 was diagnosed with pneumonia.
-Resident #1 returned to the facility within a week.
-Resident #1 was on oxygen prior to going to the hospital.
-Upon return from the hospital, Resident #1 was discharged from services with the hospice agency that was in place prior to the hospital admission.
-The facility was not given a chance to find a new hospice agency for Resident #1 before he was discharged from the previous hospice agency.
-The RCC called a new hospice agency that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 18	D 273		

same day or the next day.
-The new hospice agency came on Friday (02/21/25).
-She was not aware that Resident #1's oxygen concentrator was not working until the Surveyor told her on Monday (02/24/25).
-She spoke with Resident #1 after finding out the oxygen concentrator was not working, and he told her that he did not tell anyone because he assumed everyone knew the concentrator was not working.
-She was surprised because Resident #1 always told them when he had a problem.
-She was not aware Resident #1 stated he told the MA and RCC about the oxygen concentrator not working.

Third interview with the Administrator on 02/27/25 at 10:15am revealed:
-On Monday (02/24/25), she spoke with the Hospice Liaison and Hospice Director for the previous hospice agency and asked why Resident #1 did not receive the concentrator tubing when he returned from the hospital.
-Resident #1 was discharged from the previous hospice agency before the DME company brought the tubing.
-The previous hospice agency had the tubing for the concentrator delivered within an hour on Monday (02/24/25).

Interview with the Hospice Director for the previous hospice agency on 02/26/25 at 3:37pm revealed:
-Resident #1 was admitted as a transfer patient last year (2024).
-He was discharged from hospice with their agency 2 to 3 weeks ago, on 02/15/25, due to becoming stable.
-He fell and chose to go to the hospital and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 19	D 273		

pursue aggressive treatment.
-He chose revocation from hospice.
-Resident #1 was off oxygen for a while but started using oxygen again at the beginning of this month (February).
-Being off oxygen was why the agency considered Resident #1 to be stable.
-Resident #1 was on hospice due to COPD and requiring continuous oxygen.
-Resident #1 progressed to not using oxygen.
-Resident #1's oxygen saturation was 93% on room air on 02/12/25.
-Resident #1 was not requiring supplemental oxygen.
-He still had a standing hospice order for oxygen if he needed it for 2 to 4 liters continuous.
-He returned from the hospital either Tuesday (02/18/25) or Wednesday (02/19/25).
-On 02/18/25, their agency was contacted by the RCC regarding tubing for the oxygen concentrator.
-She sent a request to their DME company.
-She was not told that the tubing was never delivered.
-Their DME company delivered tubing on 02/18/25 and set the equipment up.
-On Monday (02/24/25), she was in the facility and was informed by the RCC and Administrator that Resident #1 was missing tubing for the oxygen concentrator.
-She went to Resident #1's room and the concentrator water bottle was half used, and the nasal cannula was present.
-The water bottle was not hooked up correctly; there was no tubing coming from the water bottle.
-The oxygen concentrator would have still worked; the oxygen just would not have been humidified.
-Although Resident #1 was not requiring supplemental oxygen, he was still a respiratory

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 20	D 273		

patient who had pneumonia that led to hospitalization.
-The concern with Resident #1 not using oxygen for 5 nights was the risk of desaturation. (Desaturation is the decrease of oxygen levels in the blood.)
-Under oxygenation could lead to hypoxia, increase fall risks and contribute to decline. (Hypoxia is the absence of enough oxygen in the tissues to sustain bodily functions.)
-Portable oxygen tanks were in the building and could be used if Resident #1's saturation levels dropped.

Second interview with the Hospice Director for the previous hospice agency on 02/27/25 at 11:02am revealed:
-She was unsure what equipment was delivered for Resident #1 on 02/18/25.
-She did not see the invoice for the equipment delivery on 02/18/25.
-The delivery date was provided to her in a messaging system.

Interview with the previous hospice agency's DME company on 02/27/25 at 11:06am and 11:11am revealed:
-Twenty-five foot tubing was delivered to the facility at 5:59pm on 02/18/25.
-It was unknown if the driver hooked the equipment up for Resident #1 on 02/18/25.

Interview with the primary care provider (PCP) on 02/27/25 at 12:19pm revealed:
-She recently took over the facility as the PCP.
-She saw Resident #1 every 30 to 60 days.
-She saw Resident #1 on Tuesday as a follow up to the 02/14/25 hospitalization.
-Resident #1 used oxygen for COPD.
-She did not write the order for continuous oxygen

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 21	D 273		

at bedtime.
-She was not aware he went five nights without oxygen.
-The concern with Resident #1 not having oxygen for 5 nights would be for hypoxia if the oxygen levels were down.

Attempted telephone interview with the MA that worked with Resident #1 for 5 nights after his return from the hospital on 02/27/25 at 11:22am was unsuccessful.

2. Review of Resident #3's current FL-2 dated 02/11/25 revealed diagnoses included chronic obstructive pulmonary disease, hypothyroidism, diabetes type 2, hypertension, cirrhosis, chronic back pain, anemia, delirium, and chronic low magnesium levels.

Review of Resident #3's Resident Register revealed:
-The resident's admission date to the facility was 06/01/23.
-The resident required assistance with scheduling appointments.
-The resident was forgetful and needed reminders.

Review of Resident #3's current assessment and care plan dated 02/11/25 revealed:
-The resident was ambulatory and used a wheelchair.
-The resident had limited range of motion in her upper extremities.
-The resident had daily incontinence of bladder and occasional incontinence of bowel.
-The resident was sometimes disoriented, forgetful, and needed reminders.
-The resident required limited assistance by staff with eating, toileting, bathing, dressing, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 22	D 273		

grooming.
-The resident required supervision by staff with ambulation and transferring.

a. Review of Resident #3's physician's order sheet dated 11/04/24 and current FL-2 dated 02/11/25 revealed orders for oxygen at 2 liters per minute (LPM) as needed (prn) during the day and oxygen at 2LPM continuous at bedtime.

Review of Resident #3's primary care provider (PCP) visit note dated 01/14/25 revealed:
-The resident was hypoxic (low oxygen levels) and suffering from tachycardia (rapid heart rate).
-The resident's oxygen saturation level was 88% on room air and her heart rate was 119.
-Staff reported the resident had acute confusion, incontinence, and was not her normal self.
-The resident was unable to maintain her oxygen saturation levels.
-The resident was sent to the hospital emergency room (ER).

Observation during tour of the facility on 02/24/25 at 9:58am revealed:
-Resident #3's room was located on the E hall.
-Resident #3 would have to walk down the E hall and then down D hall to get to the dining room and to the outside smoking area.
-There was an oxygen concentrator in the resident's room.
-There were no portable oxygen tanks in the resident's room.

Observation of Resident #3 on 02/27/25 at 9:45am revealed:
-The resident was sitting at a table in the dining room drinking coffee.
-The resident was not wearing oxygen and did not have a portable oxygen tank with her.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 23 -The resident did not appear short of breath. Interview with Resident #3 on 02/27/25 at 9:45am revealed: -She had been at the facility for about 3 years. -She had an oxygen concentrator in her room and she was currently using 2.5LPM of oxygen. -She used oxygen at night and if she was in her room during the day, she used oxygen while she watched television. -She needed portable oxygen because she sometimes got short of breath when she walked to the dining room. -Her room was a long way from the dining room. -She had talked with staff about not having portable oxygen about 2 months ago but she had not heard anything back from staff. -The staff checked her oxygen saturation levels 3 to 4 times a week and it was 90 the other day (could not recall date) and they had to put her oxygen on. Review of Resident #3's oxygen saturation log for February 2025 revealed: -The resident's oxygen saturation was checked every shift starting on first shift on 02/24/25. -The resident's oxygen saturation ranged from 90 - 97 from 02/24/25 - 02/25/25. Review of Resident #3's facility progress note dated 02/04/25 revealed: -The resident was redirected to wear her prn oxygen due to low oxygen saturation levels -The resident refused to stay in compliance with her prn oxygen. -The PCP was present inside the facility and was aware of the resident not putting on her prn oxygen when needed. Review of Resident #3's PCP visit note dated	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 24 02/04/25 revealed: -The resident was seen today for hypoxia (low oxygen levels) and confusion. -The resident was sitting in the dining room and oxygen saturation level was 88% on room air. -The resident's past medical history included chronic respiratory failure secondary to chronic obstructive pulmonary disease. -The resident was taken back to her room and put on her oxygen concentrator. -Her oxygen saturation while on oxygen at 2LPM was 94% while sitting and 95% while standing and lying down. -The PCP noted the resident had an oxygen concentrator in the resident's room but needed portable oxygen. -The PCP noted the resident was non-compliant with wearing oxygen at times. -There was no documentation indicating the PCP was aware the resident changed and used the oxygen at levels higher than 2LPM as ordered. Review of Resident #3's PCP order dated 02/04/25 revealed an order to provide portable oxygen. Interview with a personal care aide (PCA) on 02/27/25 at 8:49am revealed: -Resident #3 used oxygen periodically throughout the day. -She was not sure what the oxygen was supposed to be set on. Interview with a first shift medication aide (MA) on 02/27/25 at 1:14pm revealed: -Resident #3 was non-compliant with keeping her oxygen on 2LPM. -She had seen the resident's oxygen concentrator set on 4LPM about a month ago. -She redirected the resident and she changed it	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 25	D 273		

back to 2LPM.
-She did not recall notifying the PCP that the resident was using 4LPM instead of 2LPM.
-Resident #3 did not have portable oxygen tanks at the facility.
-She did not know why the resident did not have portable oxygen tanks.
-She thought the Resident Care Coordinator (RCC) was working on getting portable oxygen tanks for the resident.

Interview with a second shift MA on 02/27/25 at 5:39pm revealed:
-Resident #3 usually wore her oxygen at night.
-The resident could turn on the oxygen concentrator and apply the nasal canula herself.
-The resident used the oxygen "off and on" during the day.
-The resident changed the oxygen to 4LPM sometimes and staff would change it back to 2LPM.
-She thought she had verbally reported that to the PCP when the PCP was at the facility but it was not documented.
-She had never known the resident to have portable oxygen.

Interview with the RCC on 02/27/25 at 1:30pm revealed:
-Resident #3 only had an oxygen concentrator since she was admitted to the facility.
-She contacted a medical supply company around the beginning of January 2025 but she could not locate documentation.
-The MAs were responsible for making sure the resident was wearing oxygen as ordered.
-She was currently working on getting portable oxygen for Resident #3.

Second interview with the RCC on 02/27/25 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 26 3:49pm revealed: -She did not realize until she helped clean up and organize the facility's oxygen storage room in December 2024 that Resident #3 did not have any portable oxygen tanks. -She contacted some home health companies about obtaining some portable oxygen tanks for Resident #3 in December 2024. -She found out there needed to be proof (a walking test and an order) that the resident needed oxygen. -The PCP wrote an order on 02/04/25 to provide portable oxygen for Resident #3. -She did not follow-up with getting portable oxygen after the order was received on 02/04/25 because she thought "it got lost" and she forgot to follow-up. Observation of Resident #3 on 02/27/25 at 5:30pm revealed: -The resident was sitting on the side of her bed wearing her oxygen nasal canula. -The resident was holding onto the side of the bed with both hands and leaning forward. -The resident was short of breath. -The resident's oxygen concentrator was set on 2.5LPM instead of 2LPM. Interview with Resident #3 on 02/27/25 at 5:30pm revealed: -She had just walked back to her room from the outside smoking area which was near the dining room. -She was short of breath so she was using her oxygen. -She was using 2.5LPM of oxygen and it was helping with her shortness of breath. -She could turn the oxygen concentrator on and set it herself without assistance.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 27 Telephone interview with a customer service representative at a medical supply company on 02/27/25 at 4:04pm revealed: -They did not have any orders for oxygen on file for Resident #3. -A 6-minute walk test, a new prescription, and an office visit with the PCP was required for portable oxygen. Telephone interview with a customer service representative at a second medical supply company on 02/27/25 at 4:15pm revealed: -They had not received any orders for Resident #3 for oxygen. -The last order they received for Resident #3 was an order for a wheelchair a few years ago. -She spoke with someone at the facility today, 02/27/25, about requirements for portable oxygen. -There was no documentation of any calls from the facility prior to today, 02/27/25. Telephone interview with Resident #3's PCP on 02/27/25 at 12:38pm revealed: -Resident #3 had an order for oxygen 2LPM continuous at night and 2LPM prn during the day. -She was not aware the facility had not obtained portable oxygen for the resident yet. -Resident #3 needed oxygen prn when her oxygen saturation levels were low. -The resident was probably non-compliant with wearing her oxygen at times. -She was not aware the resident was using 2.5LPM of oxygen instead of 2LPM. -The facility staff should have notified her if they knew the resident was changing the setting on the oxygen concentrator. -If the resident's oxygen saturation levels were low, she was not concerned as much about the resident using 2.5LPM instead of 2LPM as	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 28	D 273		

ordered because the resident needed the oxygen.
-The facility should have notified her that the resident did not have portable oxygen yet.
-The resident needed portable oxygen to use when she was not in her room in case her oxygen levels got low and the resident was short of breath.

Attempted telephone interview with Resident #3's medical supply company who supplied the oxygen concentrator on 02/27/25 at 4:00pm was unsuccessful.

b. Review of Resident #3's facility progress notes dated 05/11/24 - 05/13/24 revealed:
-On 05/11/24: the resident hurt her foot on the bed; it was swollen and discolored: the on-call provider was called.
-On 05/12/24: mobile x-ray results were faxed to the on-call provider; the on-call provider stated to send the resident to the hospital emergency room (ER); 911 was called and the resident was transported to the hospital ER.
-On 05/13/24: the resident returned to the facility and was not to put weight on her left foot.
-On 05/20/24: the resident was out of compliance with wearing her left foot splint and not putting weight on her left foot.

Review of Resident #3's podiatry visit note dated 09/24/24 revealed:
-The resident was status post a left foot ORIF (open reduction with internal fixation). (ORIF is a method of surgically repairing a fractured foot.)
-X-rays of the resident's foot were completed at the visit due to left foot pain.
-The podiatry note indicated the resident was awaiting a boot and was to return to the podiatrist in 4 months.
-The resident's follow-up podiatry appointment

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 29	D 273		

was scheduled for 01/28/25 at 9:20am.

Review of Resident #3's hospital discharge summary dated 01/17/25 revealed:
-The resident was brought for evaluation of altered mental status and suspected urinary tract infection.
-Upon physical examination, there was a deformity to her left foot noted.
-An x-ray to the left foot showed fusion hardware traversing the tarsometatarsal joints (joint in the middle of the foot) of the first through third digits.
-There was no acute hardware complication but distal forefoot soft tissue swelling noted.
-The resident was to follow-up with the podiatrist for an appointment already scheduled for 01/28/25 at 9:20am.

Review of Resident #3's provider visit notes and facility progress notes revealed no documentation to indicate the resident was seen for a follow-up visit with the podiatrist on 01/28/25.

Interview with Resident #3 on 02/27/25 at 9:45am revealed:
-She did not remember what happened to her left foot last year, but she had to wear a cast and a boot.
-She only wore the boot a couple of days because she did not think she needed to wear it.
-She used a wheelchair during that time.
-She had not been back to see the podiatrist and she was not sure why.
-Her foot still hurt when she put all her weight on it.

Interview with the Resident Care Coordinator (RCC) on 02/26/25 at 8:15am revealed:
-Resident #3 broke her foot in May 2024 and the podiatry appointment in September 2024 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 30	D 273		

because the resident reinjured her foot.
-The appointment for 01/28/25 was a follow-up to the reinjury appointment in September 2024.
-She thought Resident #3 did not go to the follow-up podiatry appointment on 01/28/25 because there was a COVID outbreak at the facility around that time.
-The facility's transporter was responsible for scheduling and taking residents to appointments.
-The facility's transporter had a notebook with appointments.
-She did not have a system to check behind the transporter to ensure residents went to appointments.

Telephone interview with a phone operator at Resident #3's podiatrist's office on 02/26/25 at 8:34am revealed:
-Resident #3 was seen at their office on 09/24/24.
-The resident had a follow-up appointment on 01/28/25 but the resident was a "no-show" meaning the resident did not come to the appointment and no one called to cancel the appointment or reschedule the appointment at that time.
-The resident's appointment had not been rescheduled.
-The podiatrist wanted a follow-up visit to see how the resident's foot was healing.
-The facility's RCC contacted her today, 02/26/25 and wanted to reschedule the appointment.
-The resident's insurance required a new referral if it was longer than 6 months between appointments.
-They were currently booking out 3 to 4 weeks so she told the RCC that the resident would need a new order for a referral.
-Once a new order for a referral was received, they could reschedule the resident's follow-up appointment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 31 Interview with the Administrator on 02/26/25 at 4:27pm revealed: -The facility's transporter was responsible for setting up and taking residents to appointments. -She and other staff also helped transport residents to appointments at times. -The facility's transporter puts the appointments on the schedule book. -She had just returned from vacation around the time of the resident's podiatry appointment scheduled for 01/28/25 so she had not checked on follow-up appointments around that time. Interview with the facility's transporter on 02/27/25 at 1:23pm revealed: -Resident #3 had a broken foot that required surgery in May 2024. -The resident had seen a podiatrist in September 2024 and had a walking boot. -She usually took residents to appointments and if a follow-up was scheduled, she wrote it in the appointment book. -She made an error and failed to write Resident #3's follow-up appointment with the podiatrist scheduled for 01/28/25 in the appointment book. -Since the appointment was not noted in the appointment book, she did not remember to take the resident to the appointment on 01/28/25. -When she called to reschedule the missed appointment yesterday, 02/26/25, she was told the resident had to have a new referral order. -The resident was now scheduled to follow-up with the podiatrist on 03/13/25. Telephone interview with Resident #3's primary care provider (PCP) on 02/27/25 at 12:38pm revealed: -When she started working as the PCP at the facility, the resident had a previous foot injury and	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 32	D 273		

was wearing a walking boot.
-She was not aware the resident had missed a follow-up appointment with the podiatrist.
-The podiatry appointment needed to be rescheduled to follow-up on the resident's foot injury.

Attempted telephone interview with Resident #3's podiatrist on 02/26/25 at 8:47am was unsuccessful.

_____

The facility failed to ensure health care referral and follow-up for Resident #1 and Resident #3. Resident #1, who had chronic obstructive pulmonary disease (COPD), did not have oxygen tubing available to use his oxygen concentrator at night as ordered when he returned from a hospitalization for pneumonia on 02/18/25, putting the resident at risk of low oxygen levels, increased risk of falls, and could contribute to further decline in health. Resident #3, who was diagnosed with COPD and had orders for oxygen 2 liters per minute (LPM) prn (as needed) during the day and 2LPM continuous at night, did not have portable oxygen at the facility because staff failed to coordinate to obtain portable oxygen for the resident. Resident #3 also changed the settings on the oxygen concentrator to amounts higher than the 2LPM ordered, including 2.5LPM and 4LPM but staff failed to notify the primary care provider (PCP) of the non-compliance. Resident #3, who had a history of a left foot fracture requiring surgical repair, missed a follow-up appointment with a podiatrist on 01/28/25 to follow-up on her reinjured left foot which still caused her pain when she put all her weight on the left foot. The failure of the facility to provide health care referral and follow-up was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 33 The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/27/25 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 13, 2025.	D 273		
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on observations, interviews, and record	D 280	Contracted pharmacy was contacted and explained that the RN was required to complete and document the completion of performing a physical assessment of the resident as related to the resident's diagnosis or current condition per 10A NCAC 13F. 0902(c). Contracted pharmacy RN shall correct LHPS by completing physical assessments of the residents and documenting as such. The Administrator and Resident Care Coordinator received training by and Adult Care Home Consultant on the facilities responsibilities to ensure 10A NCAC 13F .0903 is followed. The Administrator and Resident Care Coordinator(RCC) received training by and Adult Care Home Consultant on implementation of a LHPS systems to check for compliance with 10A NCAC 13F. 0903.	2/27/2025 3/13/2025 4/1/2025 3/20/2025 3/20/2025 3/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 280	Continued From page 34 reviews, the facility failed to ensure the quarterly licensed health professional support (LHPS) reviews and evaluations for 3 of 5 sampled residents (#1, #3, #4) with LHPS tasks included a physical assessment, evaluation of care provided, and recommendations based on the physical assessment and evaluation of the resident including tasks for ambulation using assistive devices, transferring, oxygen administration and monitoring, testing of fingerstick blood sugars, medication through injection, and medication through inhalation. The findings are: 1. Review of Resident #3's current FL-2 dated 02/11/25 revealed: -Diagnoses included chronic obstructive pulmonary disease (COPD), hypothyroidism, diabetes type 2, hypertension, cirrhosis, chronic back pain, anemia, delirium, and chronic low magnesium levels. -There was an order for Oxygen at 2 liters per minute (LPM) as needed during the day and Oxygen at 2LPM continuous at bedtime. -There was an order for Skyrizi 150mg/ml inject 1ml SQ (subcutaneously) every 12 weeks. (Skyrizi is an injection that may be used to treat skin conditions such as psoriasis.) -There was an order for Ozempic 2mg/3ml inject 0.25mg SQ once weekly. (Ozempic is used to treat diabetes by helping manage blood sugar levels.) -There was an order for Lantus insulin 25 units SQ once a day. (Lantus is long-acting insulin used to lower blood sugar levels in diabetes.) Review of Resident #3's Resident Register revealed: -The resident's admission date to the facility was	D 280	The RN shall be required to meet with the RCC prior to exiting the facility to review the LHPS findings and to verify that the physical assessments were completed. The RCC shall sign and date each LHPS verifying review of the LHPS for accuracy and necessary follow up of recommendations made by the RN. **Monitoring System** An Adult Care Home Consultant shall audit LHPS monthly x 90days to ensure that the RN is completing and documenting a physical assessment per 10A NCAC 13F .0903. The Administrator/Resident Care Coordinator shall audit LHPS after each RN visit to ensure that the RN has completed and documented a physical assessment of the resident per 10A NCAC 13F. 0903. Ongoing non-compliance by the RN shall result in notification of the RN's supervisor and request for a replacement RN.	4/1/2025 3/20/2025 3/27/2025 4/1/2025 4/1/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 280	Continued From page 35 06/01/23. -The resident required assistance with scheduling appointments. -The resident was forgetful and needed reminders. Review of Resident #3's current assessment and care plan dated 02/11/25 revealed: -The resident was ambulatory and used a wheelchair. -The resident had limited range of motion in her upper extremities. -The resident had daily incontinence of bladder and occasional incontinence of bowel. -The resident was sometimes disoriented, forgetful, and needed reminders. -The resident required limited assistance by staff with eating, toileting, bathing, dressing, and grooming. -The resident required supervision by staff with ambulation and transferring. Review of Resident #3's facility progress notes dated 01/14/25 - 02/04/25 revealed: -On 01/14/25 at 12:36pm: 911 was called to send the resident to the hospital emergency room (ER) for her oxygen levels; the PCP was present and recommended to send the resident to the ER. -On 02/04/25: the resident was redirected to wear her prn oxygen due to low oxygen saturation levels; the resident refused to stay in compliance with her prn oxygen; the PCP was present inside the facility and was aware of the resident not putting on her prn oxygen when needed. Interview with Resident #3 on 02/27/25 at 9:45am revealed: -She had been at the facility for about 3 years. -She had an oxygen concentrator in her room and she was currently using 2.5LPM of oxygen.	D 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 280	Continued From page 36	D 280		

-She used oxygen at night and if she was in her room during the day, she used oxygen while she watched television.
-She needed portable oxygen because she sometimes got short of breath when she walked to the dining room.
-Her room was a long way from the dining room.
-She had talked with staff about not having portable oxygen about 2 months ago but she had not heard anything back from staff.
-The staff checked her oxygen saturation levels 3 to 4 times a week and it was 90 the other day (could not recall date) and they had to put her oxygen on.
-She did not remember what happened to her left foot last year, but she had to wear a cast and a boot.
-She used a wheelchair during that time but she no longer needed to use the wheelchair.
-Her foot still hurt when she put all her weight on it.
-She used Skyrizi for psoriasis and it seemed to help.
-She received insulin and Ozempic and her blood sugar was checked by staff but she could not recall how often.

Observation of Resident #3 on 02/27/25 at 5:30pm revealed:
-The resident was sitting up on the side of her bed wearing her oxygen nasal canula.
-The resident was holding onto the side of the bed with both hands and leaning forward.
-The resident was short of breath.
-The resident's oxygen concentrator was set on 2.5LPM instead of 2LPM.
-There was no portable oxygen tank in the resident's room.

Second interview with Resident #3 on 02/27/25 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 280	Continued From page 37 5:30pm revealed: -She had just walked back to her room from the outside smoking area which was near the dining room. -She was short of breath so she was using her oxygen. -She was using 2.5LPM of oxygen and it was helping with her shortness of breath. -She could turn the oxygen concentrator on and set it herself without assistance. Review of Resident #3's current Licensed Health Professional Support (LHPS) review dated 01/21/25 revealed: -The nurse documented the resident's LHPS tasks were ambulation using assistive devices, collecting and testing fingerstick blood samples, medication administration through injection, and oxygen administration and monitoring. -The nurse documented the resident's record was reviewed. -The resident used a wheelchair for mobility with staff assistance. -The resident had an order for oxygen at 2LPM continuously at night and as needed during the day. -The resident had a diagnosis of COPD. -The resident had an order for Skyrizi every 12 weeks. -There was no adverse reaction documented. -The resident was currently on a no concentrated sweets (NCS) diet with insulin and Ozempic ordered. -There was an order in place for blood sugar checks once a week. -The nurse noted to continue current plan of care, routine care for residents with diabetes mellitus. -There was no physical assessment related to the resident's LHPS tasks. -There was no physical assessment related to the	D 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 280	Continued From page 38	D 280		

resident's ambulation assistance needs.
-There was no physical assessment related to the resident's skin or foot care for a resident with diabetes.
-There was no physical assessment related to the resident's use of Skyrizi for skin conditions.
-There was no physical assessment related to the resident's oxygen use including no documentation of the resident's lung sounds or noting if the resident was having any shortness of breath, coughing, or wheezing.
-There was no physical assessment related to the resident's sites used for the injections or the blood sugar checks.
-There were no recommendations related to a physical assessment of the resident.

Refer to telephone interview with the facility's contracted LHPS nurse on 02/27/25 at 9:19am.

Refer to interview with the Resident Care Coordinator (RCC) on 02/26/25 at 10:50am.

Refer to interview with the Administrator on 02/26/25 at 4:27pm.

2. Review of Resident #4's current FL-2 dated 06/20/24 revealed:
-Diagnoses included pleural effusion (fluid build-up between the lungs and chest), diabetes mellitus, weakness, and schizoaffective disorder.
-There was an order to apply Oxygen at 3 liters per minute (LPM) at night and exercise.
-There was an order for Abilify Maintena ER 400mg IM (intramuscular) every 4 weeks. (Abilify Maintena is a long-acting antipsychotic injectable used to treat schizophrenia and mood disorders.)
-There was an order for CPAP (continuous positive air pressure) device apply in the evening and remove in the morning. (CPAP devices are

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 280	Continued From page 39 used to treat obstructive sleep apnea.) Observation of Resident #4 on 02/24/25 at 10:33am revealed: -The resident was sitting up on the side of his bed wearing an oxygen nasal canula. -The resident did not appear short of breath. -There was a wheelchair near the bed with a portable oxygen tank attached. -There was an oxygen concentrator near the bed. -There was a CPAP machine on the bedside table. Interview with Resident #4 on 02/24/25 at 10:33am revealed: -He had an oxygen concentrator and portable oxygen tanks. -He was feeling okay and denied any shortness of breath. -He usually used oxygen at night and sometimes during the day. -He used the CPAP machine at night also. -He could usually transfer himself and self-propel the wheelchair most days. Review of Resident #4's current Licensed Health Professional Support (LHPS) review dated 01/21/25 revealed: -The nurse documented the resident's LHPS tasks were ambulation using assistive devices, medication administration through injection, transferring, CPAP device, and oxygen administration and monitoring. -The nurse documented the resident's record was reviewed. -Hospice care continued. -The resident was assisted with the use of wheelchair for locomotion and transfers. -The resident was alert and pleasant. -The resident had an order for oxygen at 3LPM	D 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 280	Continued From page 40	D 280		

during exercise and at bedtime.
-The resident also had a CPAP machine.
-The resident had an order for Abilify 400mg IM injection monthly and was last administered on 01/14/25.
-The nurse noted to continue current plan of care.
-There was no physical assessment related to the resident's LHPS tasks.
-There was no physical assessment related to the resident's ambulation assistance and transferring, including how many staff were required for assistance.
-There was no physical assessment related to the resident's use of Abilify injections.
-There was no physical assessment related to the resident's use of oxygen and CPAP including no documentation of the resident's lung sounds or noting if the resident was having any shortness of breath, coughing, or wheezing.
-There was no physical assessment related to the resident's sites used for the injections or the blood sugar checks.
-There were no recommendations related to a physical assessment of the resident.

Refer to telephone interview with the facility's contracted LHPS nurse on 02/27/25 at 9:19am.

Refer to interview with the Resident Care Coordinator (RCC) on 02/26/25 at 10:50am.

Refer to interview with the Administrator on 02/26/25 at 4:27pm.

3. Review of Resident #1's FL-2 dated 11/01/24 revealed:
-Diagnoses included chronic obstructive pulmonary disease (COPD), history of cerebrovascular accident (CVA) and type 2 diabetes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 280	Continued From page 41 -The resident was documented as semi-ambulatory. -The resident required assistance with bathing and dressing. -There was an order for 2 liters of oxygen continuous at bedtime. -There was an order for Ipratropium/Albuterol Solution, 1 vial 3 times per day as needed. (Ipratropium/Albuterol Solution is a medication used via nebulizer to treat COPD and other breathing problems.) Review of Resident #1's Resident Register revealed: -The resident was admitted to the facility on 06/01/23. -The resident required assistance with bathing, nail care, shaving, getting in and out of bed, toileting, hair and grooming, skin care and scheduling appointments. -The resident used a wheelchair. Review of Resident #1's assessment and care plan dated 11/01/24 revealed: -The resident was documented as ambulatory with aide or device with limited strength and needed a wheelchair. -The resident required oxygen at night. -The resident was sometimes disoriented, forgetful and needed reminders. -The resident required limited assistance with eating, toileting, ambulation, bathing, dressing, grooming and transferring. -Staff set the table and cut meats, checked every 2 hours for incontinence, monitored for safety, and washed back and lower extremities. -Staff assisted with buttons, zippers, socks and shoes, washed hair, and shaved and filed nails. -Staff used a hoyer for transfers.	D 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 280	Continued From page 42 Observations of Resident #1's room on 02/24/25 at 11:09am revealed he had a hospital bed, trapeze bar, nebulizer and wheelchair. Observations of Resident #1 on 02/25/25 at 4:20pm revealed the resident was sitting on his rollator outside in the smoking area. Observation of Resident #1 on 02/26/25 at 10:07am revealed he was in bed receiving a breathing treatment with the medication aide (MA) present. Observation of Resident #1 on 02/27/25 at 9:54am revealed the resident was independently ambulating with a rollator to go outside to the smoking area. Interview with Resident #1 on 02/24/25 at 11:09am and 4:43pm revealed: -He suffered from COPD. -He did not sleep as well without the oxygen. -He woke up in the morning congested when he did not use oxygen at night. -The fluid from the COPD did not build up as fast when he had the oxygen at night. Second interview with Resident #1 on 02/25/25 at 4:20pm revealed he used the trapeze bar for assistance with sitting up in bed. Interview of a personal care aide (PCA) on 02/26/25 at 8:55am revealed: -She made sure Resident #1 got up for breakfast. -If he needed help getting up, she assisted him because he was not very mobile. -Resident #1 had asked for help a few times but was very independent. Review of Resident #1's current Licensed Health	D 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 280	Continued From page 43 Professional Support (LHPS) review dated 11/19/24 revealed: -The nurse documented that the LHPS tasks were ambulation using assistive device, transferring semi- or non-semi residents, inhalation of medication by machine, and oxygen administration monitoring as personal care tasks currently present. -The nurse noted that the resident was independent in ambulation utilizing wheelchair for mobility. -Staff assisted with transfers as needed. -There was an order for nebulizer treatment 3 times daily for COPD. -There was an order for oxygen at 2LPM via nasal cannula at bedtime or as needed for shortness of breath. -The resident was alert and cooperative. -The nurse noted to continue to follow plan of care. -There was no physical assessment related to any of the resident's LHPS tasks. -There was no physical assessment related to the resident's skin or foot care for a resident with diabetes. -There was no physical assessment related to the number of staff needed to assist with transfers or ambulation. -There was no physical assessment related to the resident's medication for inhalation including no documentation of the resident's lung sounds or noting if the resident was having any shortness of breath, coughing, or wheezing. -There were no recommendations related to a physical assessment of the resident. Refer to telephone interview with the facility's contracted LHPS nurse on 02/27/25 at 9:19am. Refer to interview with the Resident Care	D 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 280	Continued From page 44 Coordinator (RCC) on 02/26/25 at 10:50am. Refer to interview with the Administrator on 02/26/25 at 4:27pm. _____ Telephone interview with the facility's contracted licensed health professional support (LHPS) nurse on 02/27/25 at 9:19am revealed: -She usually assessed residents when she completed the LHPS reviews. -For example, if a resident had shortness of breath, she usually noted it on the LHPS form. -She also usually documented if she noted any concerns about LHPS tasks such as adverse reactions from injections. -She was not sure why she did not document physical assessments on the LHPS forms completed in January 2025. Interview with the Resident Care Coordinator (RCC) on 02/26/25 at 10:50am revealed: -The facility's contracted LHPS nurse came to the facility to do the LHPS reviews. -The LHPS nurse usually "lays eyes" on the residents and looks at them. -She was not sure if the LHPS nurse was doing a physical assessment related to the LHPS tasks on the residents. -Once the LHPS nurse completed the LHPS reviews, the nurse gave the documentation to the RCC. -She usually looked over the LHPS reviews to see if there were any recommendations to be followed up. -She did not check to see if the LHPS nurse completed a physical assessment because she was not aware the rule required a physical assessment. Interview with the Administrator on 02/26/25 at	D 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 280	Continued From page 45 4:27pm revealed: -The LHPS nurse came on-site to the facility to complete the LHPS reviews. -The Resident Care Coordinator (RCC) was responsible for checking the LHPS reviews for completeness. -She was not aware a physical assessment of the resident's LHPS tasks was required for the LHPS reviews. -She relied on the RCC to make sure the LHPS reviews were accurate and complete.	D 280		
D 286	10A NCAC 13F .0904(b)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (b) Food Preparation and Service in Adult Care Homes: (1) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate, and beverage containers. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure mealtime table service included enough non-disposable place settings for all residents. The findings are:	D 286	The Administrator completed an inventory of the table service items and purchased enough plates, forks, spoons, bowls for food service The Food Service Director and the Administrator shall receive training on proper place settings and requirements of 10A NCAC 13F .0904 (b)(1). A place setting inventory sheet was implemented to ensure all required place settings are available for use daily. The place setting inventory sheet shall be completed by the Food Service monthly weekly thereafter. Any items that are below the established numbers for each resident shall immediately be reported to the administrator to purchase.	2/25/2025 3/27/2025 4/7/2025 4/1/2025 4/1/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 286	Continued From page 46 Observation of the meal service during lunch on 02/25/25 between 11:45am and 1:00pm revealed: -Some residents were already sitting in the dining room prior to 11:45am. -Lunch was served starting at 12:00pm. -There were 47 residents sitting in the dining room at 12:39pm. -At 12:39pm, there were 14 residents that did not have a plate. -The dietary aide (DA) was observed picking up plates from residents who had finished eating, taking them into the kitchen and washing them immediately so other residents could be served. -The last plate was served at 12:47pm. Interview with a resident on 02/27/25 at 8:47am revealed: -She had to wait to eat sometimes because the dietary staff had to finish working. -She never had to wait while others ate but people on the other side of the dining room had to wait for others to finish eating before they ate. -Other residents had to wait to eat because dietary staff were fixing food. -They were told by dietary staff that they would bring their food when it was fixed. -They didn't have to wait long to get their plates. Interview with a 2nd resident on 02/27/25 at 9:14am revealed: -She had to wait for her food every once in a while. -Other residents would be eating while she was waiting for her food. -She was not bothered by having to wait for her food; she was used to it. -She did not know why she had to wait for her food. Interview with the Dietary Manager (DM) on	D 286	The inventory sheet shall be reviewed by the Food Service Director and administrator weekly x 90 days then monthly thereafter. Items shall be purchased that are needed.	4/1/2025
			Monitoring System An Adult Care Home Consultant shall randomly monitor food service place settings monthly x 90 days to ensure compliance with 10A NCAC 13F .0904(b) (1)	4/1/2025
			The Administrator shall monitor food service place settings monthly to ensure compliance with 10A NCAC 13F .0904(b)(1) and immediately purchase any necessary items.	4/1/2025
			Administrator shall receive guidance and consultative services from a NC Adult Care Home Consultant, who is a certified administrator with 25 years of experience in adult care home management x 90 days and then per request thereafter. Consultative services shall include training on 10A NCAC 13F Adult Care Home Regulations, Quality Assurance Systems and support guidance as needed.	3/13/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 286	Continued From page 47 02/25/25 at 12:39pm revealed: -They were short approximately 20 plates. -The Administrator had been notified in January 2025 before the previous DM left. -She notified the Administrator yesterday (02/24/25) of the plate shortage. -Not having enough plates to serve all the residents made her feel like she was rushing residents to eat and caused some residents to have to eat in front of other residents at their table. Interview with a DA on 02/26/25 at 9:10am revealed: -She had been a DA for almost 5 years. -She passed out drinks and desserts, did the dishes, swept and mopped, and changed tablecloths. -Sometimes she cooked and fixed plates. -They had been running out of plates for about a year and a half. -She told the previous DM they did not have enough plates. -The previous DM told the Administrator they did not have enough plates. -They were short approximately 14 plates. -The Resident Care Coordinator (RCC) and Administrator were told about the shortage of plates every Friday when the truck order was submitted to them. -She was unsure what happened, but no additional plates were provided. -Different residents had to wait to eat on different days, depending on what side of the dining room they started serving on. -The shortage of plates made her feel rushed to pick up plates from residents to wash them to ensure everyone was eating at the same time; it felt like she was rushing the residents to eat. -All residents were not eating at the same time.	D 286		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 286	Continued From page 48 -None of the residents complained, but their faces appeared to be saying "where is my food." -The Administrator was responsible for making sure the facility had enough plates for all residents. Interview with a personal care aide (PCA) on 02/27/25 at 12:00pm revealed: -She had observed residents waiting to eat because there were not enough plates. -Residents having to wait to eat because there were not enough plates had been going on for months. -Dietary staff had to wash plates between feedings. -There were no complaints from residents. -Residents patiently waited for their plates. -The number of residents having to wait for plates to be washed to eat varied because some dietary staff worked faster than others. Interview with the RCC on 02/26/25 at 10:12am revealed: -She was not aware there were not enough plates for all residents to eat at the same time. -She was unsure how many plates they had. -The DM was responsible for ensuring there were enough plates for all residents. -The Administrator and the DM ordered kitchen supplies. -She did not handle the ordering of kitchen supplies. -She was unsure why there was a shortage of plates. -PCAs were in the dining room daily. -No one reported the shortage of plates or residents waiting to eat due to the shortage of plates to her. -She was unsure if anyone other than PCAs periodically observed meal service.	D 286		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 286	Continued From page 49 -She observed meal service a couple of times. -The plate shortage was "kind of rough" because residents had to sit and watch others eat in front of them. Review of a receipt provided by the Administrator on 02/25/25 at 4:34pm revealed she purchased 5 boxes of plates with each box containing 12 plates. Interview with the Administrator on 02/26/25 at 11:14am revealed: -She had been the Administrator for a year and a half. -She was not aware there was a shortage of plates. -She ordered plates 3 months ago. -Residents took plates to their rooms. -The PCAs did a sweep (search) of the facility and found plates in residents' closets, drawers, and in the community bathrooms. -She was not aware 14 residents had to wait for other residents to finish eating before they could eat due to the shortage of plates. -No one reported to her that there was a shortage of plates recently, but it was reported to her a few months ago; and she purchased plates at that time. -The shortage of plates was a dignity issue for the residents; residents could have felt bad watching others eat. -She purchased 60 more plates yesterday (02/25/25).	D 286		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes:	D 296	The administrator contacted the Facility's food service vendor and received and implemented the therapeutic diet menu extensions.	2/26/2025 3/20/2025 3/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 296	Continued From page 50 (7) The facility shall have a matching therapeutic diet menu for any resident's physician-ordered therapeutic diet for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure there was a therapeutic/modified diet menu in the kitchen for food service staff to use as guidance for 5 of 5 sampled residents (#1, #2, #3, #4, #5) who had a physician's order for a chopped, no added salt (NAS) diet (#1), a chopped diet (#2), a no concentrated sweets (NCS) diet (#3), a NCS and puree diet (#5) and a low fat/low cholesterol diet (#4). The findings are: Observation of the dining room and kitchen on 02/24/25 at 2:20pm revealed: -Each table had resident name cards that included the resident's diet. -The regular menu was posted on a bulletin board in the kitchen. -A resident diet chart with therapeutic diets were posted on the bulletin board in the kitchen. 1. Review of Resident #1's current FL-2 dated 11/01/24 revealed diagnoses included hypertension, hyperlipidemia, chronic obstructive pulmonary disease (COPD), history of cerebrovascular accident (CVA), cervical spine stenosis and type 2 diabetes mellitus.	D 296	The Food Service Director and Administrator completed Food Service training based on .0904(c)(7) by and Adult Care Home Consultant and watched the DHSR online Food Service Quality Assurance training. All Food Service Staff received training on preparation and serving meals based on the residents' ordered diets and how to use the therapeutic diet menu extensions. Menus were placed in a binder that is readily available for food service to use. Diet orders were clarified with the PCP and updated per the therapeutic menus offered at the facility. Diet Spread Sheet was revised and color coded for each specific diet for the cooks reference. Diet Tray Cards were updated with color coded stickers to match the diet spread sheet.	3/20-3/27/25 3/27/25 3/20/25 3/20/25 3/20/25 3/20/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 296	Continued From page 51 Review of Resident #1's diet order sheet dated 02/14/25 revealed there was an order for a no added salt (NAS), chopped diet. Review of the facility's resident diet chart labeled as updated on 02/24/25 posted in the kitchen revealed Resident #1 was to be served a NAS, chopped meat diet. Review of the facility's menu for Tuesday, 02/25/25, for regular diets revealed Swedish meatballs, noodles, broccoli florets, wheat dinner roll, margarine, and blushing pears were to be served. Review of the posting of the lunch menu on the white board in the dining room revealed spaghetti, Brussel sprouts, fruit and a roll were to be served. Observation of the lunch meal service on 02/25/25 between 11:45am and 1:00pm revealed Resident #1 was served spaghetti, broccoli, fruit and a roll. Based on observation of the lunch meal service on 02/25/25, it could not be determined if Resident #1 was served the correct therapeutic diet due to no NAS, chopped therapeutic diet spreadsheet available for staff guidance. Refer to interview with the Dietary Manager (DM) on 02/24/25 at 2:20pm and 02/26/25 at 9:35am. Refer to interview with a dietary aide (DA) on 02/26/25 at 9:10am. Refer to interview with the Resident Care Coordinator (RCC) on 02/26/25 at 10:12am.	D 296	The Administrator, Resident Care Coordinator and Food Service Director received training by an Adult Care Home Consultant on implementation of systems to ensure that residents are receiving diets asordered by the physician. **Monitoring System** An Adult Care Home Consultant shall monitor meal service to ensure residents are served diets as ordered by their physician monthly x 90days, and shall monitor Food Service staff knowledge and use of therapeutic diet menus monthly monthly x90 days. The Administrator shall monitor meal service to ensure residents are served diets as ordered by their physician weekly x 90 days then monthly thereafter. The Administrator shall monitor the Food Service Staff knowledge and use of therapeutic diet menus weekly x 90days and then monthly thereafter.	3/20/25 3/27/2025 3/27/2025 4/1/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 296	Continued From page 52 Refer to interview with the Administrator on 02/26/25 at 11:14am. Refer to telephone interview with the primary care provider (PCP) on 02/27/25 at 12:19pm. 2. Review of Resident #2's current FL-2 dated 02/10/25 revealed diagnosis included hypertension. Review of Resident #2's diet order sheet dated 02/14/25 revealed there was an order for a chopped diet. Review of a primary care provider (PCP) progress note dated 01/21/25 revealed diagnoses included dementia, gastroesophageal reflux disease (GERD) and generalized muscle weakness. Review of the facility's resident diet chart labeled as updated on 02/24/25 posted in the kitchen revealed Resident #1 was to be served a chopped meat diet. Review of the facility's menu for Tuesday, 02/25/25, for regular diets revealed Swedish meatballs, noodles, broccoli florets, wheat dinner roll, margarine, and blushing pears were to be served. Review of the posting of the lunch menu on the white board in the dining room revealed spaghetti, Brussel sprouts, fruit and a roll were to be served. Observation of the lunch meal service on 02/25/25 between 11:45am and 1:00pm revealed Resident #2 was served spaghetti, broccoli, fruit and a roll.	D 296	Administrator shall receive guidance and consultative services from a NC Adult Care Home Consultant, who is a certified administrator with 25 years of experience in adult care home management x 90 days and then per request thereafter. Consultative services shall include training on 10A NCAC 13F Adult Care Home Regulations, Quality Assurance Systems and support guidance as needed.	3/13/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 296	Continued From page 53	D 296		

Based on observation of the lunch meal service on 02/25/25, it could not be determined if Resident #2 was served the correct therapeutic diet due to no chopped therapeutic diet spreadsheet available for staff guidance.

Refer to interview with the Dietary Manager (DM) on 02/24/25 at 2:20pm and 02/26/25 at 9:35am.

Refer to interview with a dietary aide (DA) on 02/26/25 at 9:10am.

Refer to interview with the Resident Care Coordinator (RCC) on 02/26/25 at 10:12am.

Refer to interview with the Administrator on 02/26/25 at 11:14am.

Refer to telephone interview with the primary care provider (PCP) on 02/27/25 at 12:19pm.

3. Review of Resident #3's current FL-2 dated 02/11/25 revealed:
-Diagnoses included diabetes mellitus 2, cirrhosis, hypertension, hypothyroidism, anemia, chronic low magnesium levels, and chronic obstructive pulmonary disease (COPD).
-There was an order for a no concentrated sweets (NCS) diet.

Review of Resident #3's diet order sheet dated 02/17/25 revealed there was an order for a NCS diet.

Review of the facility's resident diet chart labeled as updated on 02/24/25 posted in the kitchen revealed Resident #3 was to be served a NCS diet.

Review of the facility's menu for Tuesday,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 296	Continued From page 54	D 296		

02/25/25, for regular diets revealed Swedish meatballs, noodles, broccoli florets, wheat dinner roll, margarine, and blushing pears were to be served.

Review of the posting of the lunch menu on the white board in the dining room revealed spaghetti, Brussel sprouts, fruit and a roll were to be served.

Observation of the lunch meal service on 02/25/25 between 11:45am and 1:00pm revealed Resident #3 was served spaghetti, broccoli, fruit and a roll.

Refer to interview with the Dietary Manager (DM) on 02/24/25 at 2:20pm and 02/26/25 at 9:35am.

Refer to interview with a dietary aide (DA) on 02/26/25 at 9:10am.

Refer to interview with the Resident Care Coordinator (RCC) on 02/26/25 at 10:12am.

Refer to interview with the Administrator on 02/26/25 at 11:14am.

Refer to telephone interview with the primary care provider (PCP) on 02/27/25 at 12:19pm.

4. Review of Resident #4's current FL-2 dated 06/20/24 revealed diagnoses included pleural effusion and diabetes mellitus.

Review of Resident #4's diet order sheet dated 02/17/25 revealed there was an order for a low fat, low cholesterol diet.

Review of the facility's resident diet chart labeled as updated on 02/24/25 posted in the kitchen revealed Resident #4 was to be served a low

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 296	Continued From page 55	D 296		

cholesterol diet.

Review of the facility's menu for Tuesday, 02/25/25, for regular diets revealed Swedish meatballs, noodles, broccoli florets, wheat dinner roll, margarine, and blushing pears were to be served.

Review of the posting of the lunch menu on the white board in the dining room revealed spaghetti, Brussel sprouts, fruit and a roll were to be served.

Observation of the lunch meal service on 02/25/25 between 11:45am and 1:00pm revealed Resident #4 was served spaghetti, broccoli, fruit and a roll.

Telephone interview with the Hospice Director for Resident #4's hospice agency on 02/27/25 at 8:10am revealed:
-Resident #4 had a lot of comorbidities so anything ordered that was not followed could contribute to further health issues.
-Not preparing the food as ordered could exacerbate heart and respiratory issues because it is all related to cardiac disease and elevated cholesterol levels.
-No issues had been noted with Resident #4 related to his diet.

Refer to interview with the Dietary Manager (DM) on 02/24/25 at 2:20pm and 02/26/25 at 9:35am.

Refer to interview with a dietary aide (DA) on 02/26/25 at 9:10am.

Refer to interview with the Resident Care Coordinator (RCC) on 02/26/25 at 10:12am.

Refer to interview with the Administrator on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 296	Continued From page 56 02/26/25 at 11:14am. Refer to telephone interview with the primary care provider (PCP) on 02/27/25 at 12:19pm. 5. Review of Resident #5's current FL-2 dated 11/01/24 revealed diagnoses included dementia, gastroesophageal reflux disease (GERD), gout, diabetes mellitus 2, renal insufficiency, and history of arrhythmia. Review of Resident #5's diet order sheet dated 02/14/25 revealed there was an order for a puree, no concentrated sweets (NCS) diet. Review of the facility's resident diet chart labeled as updated on 02/24/25 posted in the kitchen revealed Resident #5 was to be served a NCS diet. Review of the facility's menu for Tuesday, 02/25/25, for regular diets revealed Swedish meatballs, noodles, broccoli florets, wheat dinner roll, margarine, and blushing pears were to be served. Review of the posting of the lunch menu on the white board in the dining room revealed spaghetti, Brussel sprouts, fruit and a roll were to be served. Observation of the lunch meal service on 02/25/25 between 11:45am and 1:00pm revealed Resident #5 was served spaghetti, broccoli, fruit and a roll. Based on observation of the lunch meal service on 02/25/25, it could not be determined if Resident #5 was served the correct therapeutic diet due to no therapeutic diet spreadsheet for puree, NCS diet available for staff guidance.	D 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 296	Continued From page 57 Refer to interview with the Dietary Manager (DA) on 02/24/25 at 2:20pm and 02/26/25 at 9:35am. Refer to interview with a dietary aide (DA) on 02/26/25 at 9:10am. Refer to interview with the Resident Care Coordinator (RCC) on 02/26/25 at 10:12am. Refer to interview with the Administrator on 02/26/25 at 11:14am. Refer to telephone interview with the primary care provider (PCP) on 02/27/25 at 12:19pm. _____ Interview with the Dietary Manager (DM) on 02/24/25 at 2:20pm revealed: -There was no therapeutic diet spreadsheet/extension available in the kitchen for staff guidance. -She determined what residents were served and how it was prepared based on the resident diet chart that was posted on the bulletin board in the kitchen as well as the cards on the tables in the dining room that listed the residents' diets. -A resident on a chopped diet received chopped up meats. Second interview with the DM on 02/26/25 at 9:35am revealed: -She did not know what a therapeutic diet spreadsheet/diet extension was. -She had been a cook at the facility for 1 year. -She became the DM in January 2025. -The Resident Care Coordinator (RCC) was responsible for ensuring the kitchen staff had the correct dietary information. -She had never seen a therapeutic diet spreadsheet.	D 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 296	Continued From page 58 -She just knew to use the blender for puree diets and to add a little bit of water to each entrée. -Residents on a no concentrated sweets (NCS) diet did not receive sweet tea, cake and cupcakes, and received yogurt or fruit. -She determined what residents on a NCS diet were supposed to receive based on the title of the diet. -Without having the therapeutic diet spreadsheet, residents may not have gotten the food they were supposed to receive. -She was not aware of the regulation regarding therapeutic diets spreadsheets. Interview with the dietary aide (DA) on 02/26/25 at 9:10am revealed: -She had been a dietary aide for almost 5 years. -She passed out drinks and desserts, did the dishes, swept and mopped, and changed tablecloths. -Sometimes she cooked and fixed plates. -She was not familiar with a therapeutic diet spreadsheets/diet extension. -She prepared food the way they had been doing it. -She used the food processor for pureed foods. -The entire kitchen staff had been mixing hot water with each individual entree for puree foods; they used about half of a small Styrofoam cup of hot water. -NCS was considered unsweetened. -Equal was used to sweeten the drinks for residents on a NCS diet. -Residents on a NCS diet received the same food as the rest of the residents. -She was not aware of the regulation regarding therapeutic diets spreadsheets. -The Administrator was responsible for ensuring the dietary staff had the therapeutic spreadsheet.	D 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 296	Continued From page 59 Interview with the RCC on 02/26/25 at 10:12am revealed: -She had been the RCC since June 2023. -She was not familiar with the therapeutic diet spreadsheet/diet extension. -She thought the therapeutic diet spreadsheet included the resident's name and the resident's diet. -She had never seen a therapeutic diet spreadsheet. -She did not know how dietary staff knew how to prepare each diet. -She was responsible for ensuring the therapeutic diet spreadsheet was available. -She was not aware of the regulation regarding therapeutic diets spreadsheets. -She was unsure how long the facility had been without the therapeutic diet spreadsheet. -Her concern with not having the therapeutic diet spreadsheet was that the food may not have been prepared correctly. Interview with the Administrator on 02/26/25 at 11:14am revealed: -She had been the Administrator for one year and a half. -She did not know what a therapeutic diet spreadsheet/diet extension was. -The sheet they used to prepare food had each resident's name and diet listed on it. -Dietary staff used the resident diet sheet and diet card on the tables to prepare the food. -They used the primary care provider (PCP) order to prepare food. -The PCP order did not specify anything other than the diet type. -If a resident's diet said no sugar, the resident gets foods with no sugar. -If a resident's diet said no salt, they get no salt. -The dietary staff did not use any type of guide	D 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 296	Continued From page 60 with directions to prepare food. -She was not aware of the regulation regarding therapeutic diet spreadsheets. -She called the company that provided the facility menus and requested the therapeutic diet spreadsheet/diet extension. Telephone interview with the facility's PCP on 02/27/25 at 12:19pm revealed: -Her concern with the facility not having a therapeutic diet spreadsheet/diet extension was that any resident could have gotten the wrong diet. -Diets prepared without the therapeutic spreadsheet could have been going against the plan of care.	D 296		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure a therapeutic diet was served as ordered for 1 of 5 sampled residents (#5) with a puree diet order. The findings are: Review of Resident #5's current FL-2 dated 11/01/24 revealed diagnoses included dementia, gastroesophageal reflux disease (GERD), gout, diabetes mellitus 2, renal insufficiency, and	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 310	Continued From page 61 history of arrhythmia. Review of Resident #5's diet order sheet dated 02/14/25 revealed there was an order for a puree, no concentrated sweets (NCS) diet. Review of the facility's resident diet chart labeled as updated on 02/24/25 posted in the kitchen revealed: -Resident #5 was to be served a NCS diet. -There was no documentation stating that Resident #5 was to be served a puree diet. Review of the facility's menu for Tuesday, 02/25/25, for regular diets revealed Swedish meatballs, noodles, broccoli florets, wheat dinner roll, margarine, and blushing pears were to be served. Review of the posting of the lunch menu on the white board in the dining room revealed spaghetti, Brussel sprouts, fruit and a roll were to be served. Observation of the lunch meal service on 02/25/25 between 11:45am and 1:00pm revealed: -Resident #5's was served spaghetti, broccoli, fruit and a roll. -The food was scooped out of a warming tray and placed on a plate in the same consistency as it was in the warmer. -The food was not pureed prior to being placed on the plate. -Resident #5's plate was put on a tray to be taken to his room. -The cups on the tray had Resident #5's name on it. -The Dietary Manager (DM) identified the tray as Resident #5's tray. -A personal care aide (PCA) took the tray to Resident #5's room.	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 310	Continued From page 62 -The Surveyor notified the RCC that Resident #5 had been served a tray of food that was not pureed. -The Surveyor and RCC went to Resident #5's room and the RCC removed the tray. Interview with the DM on 02/24/25 at 2:20pm revealed: -Each table had a diet card for each resident that specified the diet. -Therapeutic diets were listed on the wall on the resident diet chart. Interview with the DM on 02/25/25 at 12:17pm revealed Resident #5 was on a chopped diet. Interview with the DA on 02/26/25 at 9:10am revealed: -She had been a dietary aide for almost 5 years. -She passed out drinks and desserts, did the dishes, swept and mopped, and changed tablecloths. -Sometimes she cooked and fixed plates. -She knew each resident's diet because the diets were posted on the board on the resident diet chart. -Diets were also listed on the name cards on the tables. -Residents that ate in their room only had their diet listed on the resident diet chart on the board in the kitchen. -The RCC or Administrator completed the resident diet chart. -The resident diet chart was updated when a diet changed, or they received a new resident. -Resident #5 had a chopped diet. -She was not aware Resident #5's diet changed to puree on 02/14/25. -Resident #5 had been served a chopped diet all month.	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 310	Continued From page 63	D 310		

-Resident had no issues with eating or swallowing that she was aware of.
-PCAs took Resident #5 his tray.
-PCAs knew what tray each resident received because the names were listed on the plates and cups.
-Her concern with Resident #5 receiving a chopped diet plate was that he could have choked.
-Resident #5 received a chopped diet plate because the diet change to puree was not listed on the resident diet chart.
-The Administrator and the RCC were responsible for ensuring the dietary staff were provided with updated diet orders.

Interview with the DM on 02/26/25 at 9:35am revealed:
-She did not know Resident #5 was on a puree diet until Surveyor informed her on yesterday (02/24/25).
-She did not know Resident #5 was on a puree diet because it was not listed on the resident diet chart, and no one told her.
-The RCC was responsible for making sure the dietary staff had the correct diet information for residents.
-Resident #5 receiving a chopped diet plate could have caused him to choke.

Interview with a PCA on 02/27/25 at 8:16am revealed:
-PCAs rotated halls every 1 to 2 days.
-She last worked Resident #5's hall 3 days ago.
-Resident #5's food had to be chopped.
-She found out when he returned from the hospital that he was on a puree diet.
-She was unsure whether Resident #5's current diet was puree or chopped.
-Resident #5 was being served grits at one point

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 310	Continued From page 64	D 310		

due to swallowing issues.
-The PCA that worked Resident #5's hall was the PCA that gave him his tray.
-The PCA got the tray from the dietary staff in the kitchen.
-Each resident tray had the resident's name on it.
-Resident #5 had been getting a chopped diet tray.
-Resident #5 got grits and eggs every morning for breakfast.
-The eggs were scrambled, chopped.
-Resident #5's lunch was soft chopped foods.
-She went back and forth to check on Resident #5 as he ate in his room.
-Resident #5 could normally feed himself but if he needed help, they would assist.
-She had not observed Resident #5 have any issues other just not eating much.

Interview with the RCC on 02/25/25 at 12:27pm revealed:
-Resident #5 had been on a puree diet since he was discharged from the hospital.
-The diet had not been updated on the resident diet chart in the kitchen because her computer did not save the information that she put on the form.
-She posted an updated resident diet chart today.

Second interview with the RCC on 02/26/25 at 10:12am revealed:
-She was aware Resident #5 was on a puree diet.
-She was not aware the resident diet chart in the kitchen was incorrect on 02/25/25.
-She was responsible for ensuring the dietary staff have updated diet information on the residents.
-After the PCP signed diets orders, she posted the changes in the kitchen and informed the dietary staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 310	Continued From page 65 -She updated the resident diet chart as needed, if there were diet changes, supplements added, or allergy information added. -Resident #5 had been on a puree diet since being discharged from the hospital in January. -She updated the resident diet chart and placed it in the kitchen after Resident #5 returned from the hospital, date unknown. -She thought the resident diet chart was not up to date yesterday because her computer restarted in the process of her updating the document and did not save. -She did not know how long Resident #5 had been getting a chopped diet plate instead of a puree diet. -Resident #5 getting a chopped diet plate instead of a puree diet could have led to choking. Interview with the Administrator on 02/26/25 at 11:14am revealed: -She had been the Administrator for one year and a half. -She thought Resident #5 was in a chopped diet. -She was not aware Resident #5's diet changed to puree on 02/14/25. -She was not aware the resident diet chart had not been updated. -The RCC was responsible for updating the resident diet chart. -She randomly checked behind the RCC. -She last checked for updates at the end of January or beginning of February. -She did not know why the resident diet chart was not updated. -The resident diet chart should have been updated as soon as the order change was received. -She did not know the diet order changed so she did not know how long Resident #5 had been receiving a chopped diet plate instead of a puree	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 310	Continued From page 66 diet plate. -Her concern with Resident #5 receiving a chopped diet plate instead of a puree diet plate was the risk of choking. Interview with the facility's primary care provider (PCP) on 02/27/25 at 12:19pm revealed: -Resident #5 was a hospice patient. -She saw Resident #5 every 30 to 60 days. -She was unsure what his diet was. -She did not order the puree diet. -Resident #5 being given a chopped diet plate while on a puree diet could have led to inability to tolerate the diet; he may not have been able to swallow the food. -Puree diets were traditionally ordered due to dysphasia. (Dysphasia is difficulty swallowing.) -The risk of Resident #5 being served a chopped diet instead of a puree diet was choking and aspiration.	D 310		
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. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record	D 358	Resident's PCP was made aware of of missed orders. Implementation of new order tracking for tracking processing of orders and referrals, and tracking/ verification of receiving medications. Training with medication aides on the implementation of the medication tracking/processing form.	2/27/2025 2/27/2025 2/28/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 358	Continued From page 67 reviews, the facility failed to ensure medications were administered as ordered for 2 of 5 sampled residents (#3, #4) for record review including errors with a blood thinner used to treat and prevent blood clots (#4), an antibiotic for infection (#4), a medication used to lower cholesterol (#4), and a vaginal suppository used to treat yeast infections (#3). The findings are: 1. Review of Resident #4's current FL-2 dated 06/20/24 revealed diagnoses included diabetes mellitus, weakness, plural effusion, and schizoaffective disorder. Review of Resident #4's facility progress note dated 02/07/25 revealed: -The resident was sent to the hospital emergency room (ER). -The specific date and time the resident was sent to the ER was not noted. -The resident was having shortness of breath. Review of Resident #4's hospital discharge summary and after visit summary dated 02/18/25 revealed: -The resident was admitted to the hospital on 02/06/25 and discharged on 02/18/25. -The resident was admitted with symptoms of hypoxia (low oxygen levels). -The resident's primary diagnosis was pulmonary embolism (blood clot in the lung). -The resident was started on Heparin and Eliquis (Heparin and Eliquis are blood thinners used to treat and prevent blood clots.) -The chest x-ray showed mild bilateral lung opacities (areas that appear denser than normal) and the resident was started on antibiotics for suspected pneumonia.	D 358	Medication Aides, Administrator, RCC received training on processing of medication orders to include follow up on medications that are not received and the necessary steps to assure medications are given as ordered. Administrator and RCC received training on assuring quality assurance systems are in place to monitor medication management per 10A NCAC 13F..1000, and in particular 10A NCAC 13F. 1004a Administrator shall receive guidance and consultative services from a NC Adult Care Home Consultant, who is a certified administrator with 25 years of experience in adult care home management x 90 days and then per request thereafter. Consultative services shall include training on 10A NCAC 13F Adult Care Home Regulations, Quality Assurance Systems and support guidance as needed. **Monitoring System** Quality Assurance Adult Care Home Consultant was contracted to review medication policy and procedures and to audit medication administration monthly x 90 days(cont, page 67)	3/13/2025 3/13/2025 3/20/2025 3/27/2025 3/13/2025 3/13/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 358	Continued From page 68 -Other diagnoses included acute on chronic respiratory failure with hypoxia, congestive heart failure, hypertension, obstructive sleep apnea, and schizophrenia. -There was a discharge order for the resident to start taking Eliquis 5mg 1 tablet twice a day for 180 doses (90 days). -There was a discharge order to start taking Cefdinir 300mg 1 capsule twice a day for 3 doses. (Cefdinir is an antibiotic used to treat infections.) -There was a discharge order to start taking Atorvastatin 10mg 1 tablet once a day for 35 doses, with a note to start taking on 02/19/25. (Atorvastatin is used to lower cholesterol.) -There was documentation on the discharge form to pick up the medications at the hospital pharmacy and the open hours for the pharmacy were 24 hours a day. Review of Resident #4's February 2025 medication administration record (MAR) revealed: -There was a handwritten entry for Eliquis 5mg 1 tablet 2 times a day for a total of 180 doses. -Eliquis was scheduled to be administered at 7:00am and 7:00pm. -Staff documented the date of the Eliquis order as 02/18/25. -Documentation for Eliquis was blank on 02/18/25 and 02/19/25 with a line marked through it with no reason noted. -Eliquis was documented as not being administered on 02/20/25 at 7:00am due to waiting for pharmacy delivery. -Administration of Eliquis ordered on 02/18/25 was documented as starting on 02/20/25 at 7:00pm. -There was a handwritten entry for Cefdinir 300mg 1 capsule 2 times a day for 3 doses scheduled at 7:00am and 7:00pm.	D 358	Continued from page 68 to assure compliance with 10A NCAC 13F .1004(a) and the facilities policies and procedures. Administrator and RCC shall randomly audit medication orders and resident records monthly x 90 to assure residents are receiving medications as ordered and that policy and procedures are followed. Any staff identified as not following policy and procedures shall receive additional training and/ or corrective actions.	3/27/2025 2/28/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 358	Continued From page 69 -Staff documented the date of the Cefdinir order as 02/18/25. -Documentation for Cefdinir was blank on 02/18/25 and 02/19/25 with a line marked through it with no reason noted. -Documentation for Cefdinir was circled initials on 02/20/25 at 7:00am and 7:00pm with no reason noted. -Administration of Cefdinir ordered on 02/18/25 was documented as starting on 02/21/25 at 7:00am. -There were 3 doses of Cefdinir documented as administered from 7:00am on 02/21/25 through 7:00am on 02/22/25. -There was an entry for Atorvastatin 10mg 1 tablet one time a day for 35 doses scheduled at 7:00pm. -Staff documented the date of the Atorvastatin order as 02/18/25. -Documentation for Atorvastatin was blank on 02/19/25 with a line marked through it with no reason noted. -Documentation for Atorvastatin was blank on 02/20/25 with no reason noted. -Administration of Atorvastatin ordered to start on 02/19/25 was documented as starting on 02/21/25 at 7:00pm. Observation of Resident #4's medications on hand on 02/27/25 at 10:09am revealed: -There was a supply of Eliquis 5mg tablets dispensed on 02/19/25 by the facility's contracted pharmacy. -There were 3 of 16 Eliquis 5mg tablets remaining. -There was a supply of Atorvastatin 10mg dispensed on 02/19/25 by the facility's contracted pharmacy. -There were 2 of 8 Atorvastatin 10mg tablets remaining.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 358	Continued From page 70	D 358		

-There were no Cefdinir tablets on hand.
-There were no medications dispensed by the hospital pharmacy on hand.

Interview with Resident #4 on 02/27/25 at 11:35am revealed:
-He was in the hospital recently because of his lungs and heart.
-He was breathing better now than he was then.
-He was not sure when he started receiving new medications ordered while he was in the hospital.

Interview with a medication aide (MA) on 02/27/25 at 1:09pm revealed:
-She was not sure why there was a delay in starting Resident #4's Eliquis, Cefdinir, and Atorvastatin.
-She was not working on the morning of 02/20/25 so she was not sure why those medications were not administered on that morning.

Telephone interview with a Quality Assurance Specialist at the facility's contracted pharmacy on 02/27/25 at 2:30pm revealed:
-They did not receive Resident #4's orders for Eliquis, Cefdinir, and Atorvastatin until 02/19/25.
-According to pharmacy records, there was inclement weather on the night of 02/19/25 so no deliveries were made by the pharmacy.
-If they had received the orders on 02/18/25, the medications could have been dispensed and delivered on 02/18/25 because the pharmacy made routine deliveries on 02/18/25.

Interview with the Resident Care Coordinator (RCC) on 02/27/25 at 1:30pm revealed:
-She or the MAs were responsible for faxing orders to the pharmacy when the orders were received.
-She and the MAs were responsible for reviewing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 358	Continued From page 71	D 358		

any hospital forms when a resident returned to the facility from a hospital stay.
-She and the MAs were responsible for following any orders or instructions on the hospital discharge forms.
-When a resident was being discharged from the hospital, she usually asked the hospital to dispense any new prescriptions so there would not be a delay in getting the medications.
-She did not recall speaking with anyone at the hospital about new medications for Resident #4 when he was discharged.
-Resident #4 usually got his medications from a Veteran's Administration (VA) pharmacy but some medications were filled by the facility's contracted pharmacy if they could not get them from the VA in a timely manner.
-She overlooked the instructions on the discharge paperwork that indicated Resident #4's Eliquis, Cefdinir, and Atorvastatin were sent to the hospital pharmacy and ready to be picked up on the day he was discharged, 02/18/25.
-The facility's policy was for medications such as antibiotics for infections and blood thinners to be started immediately.
-Resident #4's new medications should have been picked up at the hospital pharmacy by facility staff when the resident was discharged on 02/18/25.
-It was an oversight on her part.

Interview with the Administrator on 02/27/25 at 1:35pm revealed:
-She was not aware there had been a delay in starting Resident #4's medications.
-The RCC was responsible for reviewing hospital discharge paperwork and faxing orders to the pharmacy.
-If the RCC was not available, the MAs were responsible for faxing orders to the pharmacy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 358	Continued From page 72 Telephone interview with the facility's contracted primary care provider (PCP) on 02/27/25 at 12:50pm revealed: -She was concerned that the delay in starting Eliquis could have caused the resident to have another pulmonary embolism. -The delay in Resident #4 receiving the Cefdinir could have exacerbated the infection in his lungs (pneumonia). -She was not as concerned about the delay in starting Atorvastatin as it was not harmful to the resident for it to be delayed 2 days. Attempted telephone interview with Resident #4's VA PCP on 02/27/25 at 5:00pm was unsuccessful. 2. Review of Resident #3's current FL-2 dated 02/11/25 revealed diagnoses included chronic obstructive pulmonary disease, hypothyroidism, diabetes type 2, hypertension, cirrhosis, chronic back pain, anemia, delirium, and chronic low magnesium levels. Review of Resident #3's primary care provider (PCP) order dated 01/07/25 revealed: -There was an order for Miconazole 200mg vaginal suppository at bedtime nightly for 3 nights. -The resident's diagnoses written on the order form were vaginal itching and vulvovaginal candidiasis (yeast infection). Review of Resident #3's January 2025 medication administration record (MAR) revealed: -There was a handwritten entry for Miconazole 200mg vaginal suppositories insert 1 vaginally at bedtime for 3 nights. -Miconazole was scheduled for 7:00pm.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 358	Continued From page 73 -There was no Miconazole suppositories documented as administered. -There were 8 days with circled initials on 01/09/25 - 01/14/25, 01/21/25, and 01/22/25. -Handwritten documentation on the back of the MAR noted "Miconazole not done, awaiting delivery". Observation of Resident #3's medications on hand on 02/26/25 at 9:35am revealed there were no Miconazole vaginal suppositories available for administration. Telephone interview with the Quality Assurance Specialist at the facility's contracted pharmacy on 02/27/25 at 2:30pm revealed the pharmacy never dispensed any Miconazole vaginal suppositories for Resident #3 because they never received the order. Interview with Resident #3 on 02/27/25 at 9:45am revealed: -She had a yeast infection and a urinary tract infection in January 2025. -She did not get any Miconazole vaginal suppositories in January 2025 and she was not sure why. -She denied any current symptoms of vaginal yeast infection. Interviews with the Resident Care Coordinator (RCC) on 02/26/25 at 8:15am and 02/27/25 at 1:30pm revealed: -She or the medication aides (MAs) were responsible for faxing orders to the pharmacy. -She was not sure why Resident #3's Miconazole order did not get faxed to the pharmacy. -She thought she had faxed the order to the pharmacy, but she could not locate it in the computer system.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 358	Continued From page 74 -She usually checked the MARs monthly for accuracy. -She probably overlooked the Miconazole not being administered. Interview with the Administrator on 02/27/25 at 1:35pm revealed: -The RCC was responsible for faxing medication orders to the pharmacy. -If the RCC was not at the facility, the MAs were responsible for faxing the orders to the pharmacy. Telephone interview with Resident #3's PCP on 02/27/25 at 12:38pm revealed: -She was not aware Resident #3 did not receive any Miconazole vaginal suppositories as ordered on 01/07/25. -The resident was complaining of vaginal itching and symptoms of a vaginal yeast infection. -Not receiving the Miconazole suppositories as ordered could have caused the resident's itching to continue and the yeast infection could have gotten worse. _____ The facility failed to administer medications as ordered to Resident #3 and Resident #4. Resident #4 was delayed in receiving a blood thinner and an antibiotic after a hospitalization for a blood clot in his lungs and suspected pneumonia, putting the resident at risk of having another blood clot and exacerbating the infection. Resident #3 was not administered a medication used to treat vaginal yeast infections due to the facility failing to fax the order to the pharmacy, putting the resident at risk of continued itching and worsening infection. The failure of the facility to administer medications as ordered was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 358	Continued From page 75 The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/27/25 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 13, 2025.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record	D 367	Resident's PCP's were contacted for clarification of oxygen orders. MARS were updated with clarification orders and clear guidance on oxygen use. Training with medication aides on documentation of oxygen use, both continuous and as needed. Medication Aides, Administrator, RCC received training on accuracy of MAR's and requirements per 10A NCAC 13F. 1004(j) Administrator and RCC received training on assuring quality assurance systems are in place to monitor medication management per 10A NCAC 13F..1000, and in particular 10A NCAC 13F. 1004j Medication Aides shall receive monhtly training on MAR accuracy monthly x 90's and quarterly thereafter.	3/20/2025 3/20/2025 3/20/2025 3/27/2025 3/13/2025 3/13/2025 3/20/2025 3/27/2025 4/1/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 367	Continued From page 76 reviews, the facility failed to ensure the medication administration records (MARs) were accurate for 3 of 5 sampled residents (#1, #3, #4) for the use of continuous and/or prn (as needed) oxygen. The findings are: 1. Review of Resident #3's current FL-2 dated 02/11/25 revealed: -Diagnoses included chronic obstructive pulmonary disease, hypothyroidism, diabetes type 2, hypertension, cirrhosis, chronic back pain, anemia, delirium, and chronic low magnesium levels. -There was an order for Oxygen at 2 liters per minute (LPM) as needed during the day and Oxygen at 2LPM continuous at bedtime. Review of Resident #3's primary care provider (PCP) visit note dated 01/14/25 revealed: -The resident was hypoxic (low oxygen levels) and suffering from tachycardia (rapid heart rate). -The resident's oxygen saturation level was 88% on room air and her heart rate was 119. -Staff reported the resident had acute confusion, incontinence, and was not her normal self. -The resident was unable to maintain her oxygen saturation levels. -The resident was sent to the hospital emergency room (ER). Review of Resident #3's PCP visit note dated 02/04/25 revealed: -The resident was seen today for hypoxia (low oxygen levels) and confusion. -The resident was sitting in the dining room and oxygen saturation level was 88% on room air. -The resident's past medical history included chronic respiratory failure secondary to chronic	D 367	Administrator shall receive guidance and consultative services from a NC Adult Care Home Consultant, who is a certified administrator with 25 years of experience in adult care home management x 90 days and then per request thereafter. Consultative services shall include training on 10A NCAC 13F Adult Care Home Regulations, Quality Assurance Systems and support guidance as needed. **Monitoring System** Quality Assurance Adult Care Home Consultant was contracted to review medication policy and procedures and to audit medication administration monthly x 90 days. to assure compliance with 10A NCAC 13F .1004(j) and the facilities policies and procedures. Administrator and RCC shall randomly audit medication orders and resident records monthly x 90 to assure residents are receiving medications as ordered and that policy and procedures are followed.	3/13/2025 3/13/2025 3/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 367	Continued From page 77 obstructive pulmonary disease. -The resident was taken back to her room and put on her oxygen concentrator. -Her oxygen saturation on 2LPM was 94% while sitting and 95% while standing and lying down. -The PCP noted the resident had an oxygen concentrator in the resident's room but needed portable oxygen. -The PCP noted the resident was non-compliant with wearing oxygen at times. Interview with Resident #3 on 02/27/25 at 9:45am revealed: -She had been at the facility for about 3 years. -She had an oxygen concentrator in her room and she was currently using 2.5LPM of oxygen. -She used oxygen at night and if she was in her room during the day; she used oxygen while she watched television. Review of Resident #3's December 2024 medication administration record (MAR) revealed: -There was an entry for oxygen at 2LPM as needed during the day. -There was no documentation to indicate any prn oxygen had been used. -There was an entry for oxygen at 2LPM continuous at bedtime scheduled at 8:00pm. -Documentation for oxygen at 2LPM continuous at 8:00pm was blank from 12/01/24 - 012/31/24 with no reason for the omissions documented. Review of Resident #3's January 2025 MAR revealed: -There was an entry for oxygen at 2LPM as needed during the day. -There was no documentation to indicate any prn oxygen had been used. -There was an entry for oxygen at 2LPM continuous at bedtime scheduled at 8:00pm.	D 367	Any staff identified as not following policy and procedures shall receive additional training and/ or corrective	2/28/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 367	Continued From page 78 -Oxygen at 2LPM continuous was documented as administered at 8:00pm from 01/01/25 - 01/31/25 except on 01/05/25 when it was blank with no reason for the omission and 01/14/25 - 01/17/25 when the resident was in the hospital. -There was no documentation to indicate the resident was non-compliant with using Oxygen at the ordered amount of 2LPM at times. Review of Resident #3's February 2025 MAR revealed: -There was an entry for oxygen at 2LPM as needed during the day. -There was no documentation to indicate any prn oxygen had been used. -There was an entry for oxygen at 2LPM continuous at bedtime scheduled at 8:00pm. -Oxygen at 2LPM continuous was documented as administered at 8:00pm from 02/01/25 - 02/23/25 except on 02/05/25 and 02/06/25 when the resident was in the hospital. -There was no documentation to indicate the resident was non-compliant with using Oxygen at the ordered amount of 2LPM at times. Observation of Resident #3 on 02/27/25 at 5:30pm revealed: -The resident was sitting up on the side of her bed wearing her oxygen nasal canula. -The resident was holding onto the side of the bed with both hands and leaning forward. -The resident was short of breath. -The resident's oxygen concentrator was set on 2.5LPM instead of 2LPM. Interview with Resident #3 on 02/27/25 at 5:30pm revealed: -She had just walked back to her room from the outside smoking area which was near the dining room.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 367	Continued From page 79 -She was short of breath, so she was using her oxygen. -She was using 2.5LPM of oxygen and it was helping with her shortness of breath. -She could turn the oxygen concentrator on and set it herself without assistance. Interview with a second shift medication aide (MA) on 02/27/25 at 5:39pm revealed: -Resident #3 usually wore her oxygen at night. -The resident could turn on the oxygen concentrator and apply the nasal canula herself. -The resident used the oxygen "off and on" during the day. -When she initialed the oxygen at 8:00pm, that meant she had gone by the resident's room and the resident was using the oxygen and the setting was checked. -She could not explain why there was no prn oxygen documented as administered on the MARs. Interview with the Resident Care Coordinator (RCC) on 02/26/25 at 8:15am revealed: -For the December 2024 MAR, the MAs forgot to document the resident used oxygen at night. -Resident #3 usually used her oxygen at night. -The resident sometimes used oxygen during the day if she needed it, which should also be documented on the MAR. -The MAs should document on the MAR if the resident was non-compliant with the oxygen orders. -She usually checked the MARs monthly for accuracy. -She probably overlooked the omissions for Resident #3's prn and scheduled oxygen. Refer to interview with the RCC on 02/26/25 at 8:15am.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 367	Continued From page 80 Refer to interview with the Administrator on 02/27/25 at 1:35pm. 2. Review of Resident #4's current FL-2 dated 06/20/24 revealed: -Diagnoses included pleural effusion (fluid build-up between the lungs and chest), diabetes mellitus, weakness, and schizoaffective disorder. -There was an order to apply Oxygen at 3 liters per minute (LPM) at night and exercise. Observation of Resident #4 on 02/24/25 at 10:33am revealed: -The resident was sitting up on the side of his bed wearing an oxygen nasal canula. -The resident did not appear short of breath. Interview with Resident #4 on 02/24/25 at 10:33am revealed: -He had an oxygen concentrator and portable oxygen tanks. -He was feeling okay and denied any shortness of breath. -He usually used oxygen at night and sometimes during the day. Review of Resident #4's facility progress note dated 02/07/25 revealed: -The resident was sent to the hospital emergency room (ER). -The resident was having shortness of breath. Review of Resident #4's hospital discharge summary and after visit summary dated 02/18/25 revealed: -The resident was admitted to the hospital on 02/06/25 and discharged on 02/18/25. -The resident was admitted with symptoms of hypoxia (low oxygen levels).	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 367	Continued From page 81 -The resident's primary diagnosis was pulmonary embolism (blood clot in the lung). Review of Resident #4's December 2024 medication administration record (MAR) revealed: -There was an entry to apply oxygen at 3LPM during night and exercise. -There was no scheduled time for the administration of oxygen noted on the MAR. -In the section used to document the scheduled time, "FYI" (for your information) was printed in the time section. -Documentation to apply oxygen at 3LPM during night and exercise was blank from 12/01/24 - 012/31/24 with no reason for the omissions documented. Review of Resident #4's January 2025 MAR revealed: -There was an entry to apply oxygen at 3LPM during night and exercise. -There was no scheduled time for the administration of oxygen noted on the MAR. -In the section used to document the scheduled time, "FYI" was printed in the time section. -Documentation to apply oxygen at 3LPM during night and exercise was blank from 01/01/25 - 01/31/25 with no reason for the omissions documented. Review of Resident #4's February 2025 MAR dated 02/01/25 - 02/24/25 revealed: -There was an entry to apply oxygen at 3LPM during night and exercise. -There was no scheduled time for the administration of oxygen noted on the MAR. -In the section used to document the scheduled time, "FYI" was printed in the time section. -Documentation to apply oxygen at 3LPM during night and exercise was blank from 02/01/25 -	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 367	Continued From page 82 02/24/25 with no reason for the omissions documented. Interview with a second shift medication aide (MA) on 02/27/25 at 5:39pm revealed: -Resident #4 usually wore oxygen at night. -She did not document her initials on the MAR for Resident #4's oxygen because there was no scheduled time, and it was "FYI only". -She did not think she needed to document the resident's oxygen on the MAR because it was listed as "FYI". Interview with the Resident Care Coordinator (RCC) on 02/26/25 at 8:15am revealed: -Resident #4 usually used oxygen at night. -The MAs should document the resident's oxygen use on the MAR. -She had not noticed there was no scheduled time for Resident #4's oxygen listed on the MAR. -There should have been a scheduled time listed on the MAR, not "FYI". -She probably overlooked the missing scheduled time and the omissions for Resident #4's oxygen. Refer to interview with the RCC on 02/26/25 at 8:15am. Refer to interview with the Administrator on 02/27/25 at 1:35pm. 3. Review of Resident #1's current FL-2 dated 11/01/24 revealed: -Diagnoses included hypertension, hyperlipidemia, chronic obstructive pulmonary disease (COPD), history of cerebrovascular accident (CVA), cervical spine stenosis and type 2 diabetes mellitus. -There was an order for 2 liters of oxygen continuous at bedtime.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 367	Continued From page 83 Review of Resident #1's Resident Register revealed he was admitted to the facility on 06/01/23. Review of Resident #1's medication administration record (MAR) for February 2025 revealed: -There was a computerized entry for Oxygen at 2 liters per minute continuous via nasal cannula at bedtime only to be administered at 8:00pm. -There was handwritten documentation that Oxygen was administered at 8:00pm on 02/18/25 to 02/23/25. Interview with Resident #1 on 02/24/25 at 11:09am and 4:43pm revealed: -He suffered from COPD. -He was in the hospital last week for pneumonia. -He had not been able to use the oxygen since he returned from the hospital. -He had not been able to use the oxygen since last Wednesday night (02/19/25) due to missing tubing. -Facility staff and hospice were working to obtain the tubing for oxygen concentrator. -He had no issues breathing at night without the oxygen. -He did not sleep as well without the oxygen. -He woke up in the morning congested when he did not use oxygen at night. -The fluid from the COPD did not build up as fast when he had the oxygen at night. -The oxygen was working prior to his admission to the hospital. -When he returned from the hospital, one of the tubes was missing that went to the oxygen concentrator. -He told the medication aide (MA) and Resident Care Coordinator (RCC) Wednesday (02/19/25)	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 367	Continued From page 84	D 367		

when he returned that the tube was missing.
-He was told 2 or 3 times by facility staff that they were working on obtaining the tubing needed for the oxygen concentrator.
-The tubing was brought to him today (02/24/25) and the oxygen concentrator was working.
-The new hospice agency delivered a new oxygen concentrator today (02/24/25).

Second interview with Resident #1 on 02/27/25 at 10:38am revealed:
-When he returned from the hospital, all the tubing for the oxygen concentrator was missing.
-When the tubing was provided, the short piece that goes from the water bottle to the front was missing so the oxygen was not blowing.
-He did not know the short piece was missing until the hospice nurse told him that same day, the day that he received the big tube.
-He had the portable oxygen tank in his room for about 1 year.
-He was not offered portable oxygen during the time he was without the tubing for the oxygen concentrator.
-He did not wear the oxygen for 4 days because it was not blowing.
-The facility got the correct tubing the day before he got the equipment from the new hospice agency.

Interview with a MA on 02/27/25 at 5:21pm revealed:
-Initialing in the boxes for each day on the MAR meant the medication had been administered.
-For oxygen, initialing in the boxes for each day meant the resident either already had the oxygen on or the oxygen was placed on him.

Interview with the RCC on 02/24/25 at 12:20pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 367	Continued From page 85 -Resident #1 went to the hospital after a fall on 02/14/25 and returned last Tuesday (02/18/25). -She found out on Wednesday (02/19/25) that Resident #1 was missing tubing for the oxygen concentrator. -She called the hospice agency on Wednesday (02/19/25) to request tubing for Resident #1's oxygen concentrator. -The hospice agency came out Wednesday (02/19/25) and was supposed to return with tubing for the oxygen concentrator; but never returned. -She found out on Wednesday (02/19/25) that the hospice agency was not going to continue providing services to Resident #1 due to insurance issues. -A new hospice agency admitted Resident #2 for services on Friday (02/21/25). Second interview with the RCC on 02/26/25 at 10:12am revealed: -When Resident #1 returned from the hospital, the tubing that went from the oxygen concentrator to the part that holds the water, as well as the long tubing with the nasal cannula, was gone. -She was not informed that the oxygen concentrator tubing was missing until the day after Resident #1 returned from the hospital. -She called the previous hospice agency to get the tubing. -The previous hospice agency brought the nasal cannula piece later that day but the piece that went to the water tank was still missing. -Later that day the hospice agency told her she could bypass the water and just use oxygen. -She was unaware that the oxygen concentrator could still be used without the water tank tubing. -Resident #1 went one night without the oxygen. -She told Resident #1 he could still use oxygen without the water tank tubing.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 367	Continued From page 86 -She was not aware Resident #1 was without oxygen for 5 nights. Third interview with the RCC on 02/27/25 at 9:00am revealed: -She found out the day after (that next morning, 02/19/25) Resident #1 returned from the hospital that all of the tubing for the oxygen concentrator was missing. -She called the previous hospice agency for tubing, and they only brought the tubing that went from the water bottle to the nasal canula. -She plugged the tubing directly into the concentrator that same day because the hospice agency told her to. -She was not aware of any other issues with the concentrator. -Resident #1 was admitted to a new hospice agency on Saturday (02/15/25). -On Monday (02/24/25), when the Surveyor told her Resident #1 was having issues with the concentrator, she called the new hospice agency and asked for his new equipment. Interview with the Administrator on 02/24/25 at 11:41am revealed she was not aware Resident #1 had issues with his oxygen concentrator that caused him to be without oxygen. Second interview with the Administrator on 02/26/25 at 11:14am revealed she was not familiar with the MAR documentation and how the form should have been used. Attempted telephone interview with the MA that worked with Resident #1 for 5 nights and documented on the MAR after his return from the hospital on 02/27/25 at 11:22am was unsuccessful.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 367	Continued From page 87 Refer to interview with the RCC on 02/26/25 at 8:15am. Refer to interview with the Administrator on 02/27/25 at 1:35pm. _____ Interview with the Resident Care Coordinator (RCC) on 02/26/25 at 8:15am revealed: -She was responsible for making sure the MARs were accurate. -She usually checked the MARs monthly for accuracy. Interview with the Administrator on 02/27/25 at 1:35pm revealed: -The MAs should document the administration of oxygen on the MARs. -The RCC was responsible for checking the MARs for accuracy. -She relied on the RCC to make sure the MARs were accurate and documented correctly.	D 367		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by:	D 451	Administrator and RCC Received training on 10A NCAC 13F . 1212(a) by and Adult Care Home Consultant. Implementation of daily communication with Administrator, RCC, Med Aides, Supervisors and other lead staff to discuss daily operations to include resident incident and accidents, and proper documentation, reporting and follow up is completed in a timely manner per 10A NCAC 13F. 1212	3/27/2025 3/13/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 451	Continued From page 88 Based on observations, interviews, and record reviews, the facility failed to ensure incident an accident report involving emergency room (ER) evaluation after a fall for 1 of 5 sampled residents (#1) was sent to the Department of Social Services (DSS). The findings are: Review of the facility's undated Accidents and Incidents Policy revealed: -The purpose of the policy was to ensure accidents and incidents were referred and followed up in a timely manner to meet the safety, behavior and medical needs of the resident. -Under the heading "Procedures" and sub-heading "Handling Accidents and incident and follow up care for the resident": number 3 stated The Supervisor in Charge/designee would ensure that proper documentation and notification was completed. -Incidents that required more than first aid treatment should be faxed to the local Department of Social Services (DSS) within 48 hours of the incident. Review of Resident #1's current FL-2 dated 11/01/24 revealed diagnoses included hypertension, hyperlipidemia, chronic obstructive pulmonary disease (COPD), history of cerebrovascular accident (CVA), cervical spine stenosis and type 2 diabetes mellitus and bipolar disorder. Review of Resident #1's handwritten progress note dated 02/14/25 and timed at 7:05pm revealed: -Resident #1 was found on the floor. -He hit his head and both knees were hurting. -He was transported to the hospital by emergency	D 451	**Monitoring System** Implementation of daily communication meetings(M-F) to assure resident accidents and incidents are documented and reported to DSS as per 10A NCAC 13F .1212. Administrator shall sign off on all incident reports to assure accurate reporting and documentation. Fax and /or email confirmation shall be kept with any incident reports sent to DSS. Adult Care Home Consultant shall monitor accident/incident reporting monthly x 90 days. Administrator shall receive guidance and consultative services from a NC Adult Care Home Consultant, who is a certified administrator with 25 years of experience in adult care home management x 90 days and then per request thereafter. Consultative services shall include training on 10A NCAC 13F Adult Care Home Regulations, Quality Assurance Systems and support guidance as needed.	3/13/2025 3/20/2025 3/20/2025 4/1/2025 3/13/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 451	Continued From page 89	D 451		

medical services (EMS).

Review of Resident #1's incident and accident report dated 02/14/25 revealed:
-The time of the event was 7:05; am or pm was not documented.
-The type of the event was "found on the floor."
-The location of the incident was the resident's room.
-The area of injury was the head and knee; left or right was not documented.
-The nature of the injury was not documented.
-Vital signs were taken and documented.
-The hospice agency was notified at 7:36pm.
-There was no notification of the regulatory agency documented.
-Medical attention was necessary.
-The physician was notified.
-The resident was transported by EMS.
-The description of recommendations from the physician was not documented.
-The form was not signed by the Administrator or designee.

Review of email correspondence provided by the Resident Care Coordinator (RCC) on 02/26/25 revealed:
-She emailed the DSS Adult Home Specialist (AHS) on 02/25/25 at 11:43am stating she faxed the incident report but was unsure who it went to and wanted to make sure the report was received since the resident was sent to the hospital.
-The AHS asked for the fax confirmation.
-The RCC advised she did not locate the fax confirmation.
-The AHS acknowledged receipt of the emailed report and provided the fax number to submit all incident reports.

Interview with the DSS AHS on 02/27/25 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026071	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND CREEK ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 451	Continued From page 90 8:07am revealed: -She received an Incident/Accident report via e-mail yesterday (02/26/25) from the RCC for Resident #1's fall on 02/14/25 and EMS transport to the hospital. -The RCC told her she sent the Incident/Accident report by fax previously but could not provide confirmation. -She did not receive an Incident/Accident report for Resident #1's fall on 02/14/25 prior to yesterday (02/26/25).	D 451		