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 _____	R 05/21/2025

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 a follow-up survey from 05/20/25 to 05/21/25.	D 000		
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: FOLLOW-UP TO TYPE B VIOLATION. The Type B Violation was abated. Non-compliance continues. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 3 residents (#6, #7) observed during the medication pass including errors with a medication for mild to moderate pain (#6, #7). The findings are: The medication error rate was 8% as evidenced by 2 errors out of 25 opportunities during the 7:00am/8:00am medication pass on 05/21/25. a. Review of Resident #6's current FL-2 dated 09/18/24 revealed: -Diagnoses included chronic pain, hypertension, hyperthyroidism, gastroesophageal reflux	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 _____	R 05/21/2025

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 1	D 358		

disease, hyperlipidemia, and constipation.
-There was an order for Acetaminophen 500mg 1 tablet once a day. (Acetaminophen is used for mild to moderate pain.)

Observation of the 7:00am medication pass on 05/21/25 revealed:
-The medication aide (MA) prepared and administered one Acetaminophen 650mg tablet to Resident #6 at 7:32am.
-The resident was administered 650mg of Acetaminophen instead of 500mg as ordered.

Interview with the MA on 05/21/25 at 10:18am revealed:
-Resident #6's family member usually brought Acetaminophen to the facility for the resident.
-The MA on duty usually checked the MARs to make sure the correct medication was brought by a family member.
-She was not on duty when Resident #6's Acetaminophen was brought so she did not check it in.
-She had not noticed when she was administering medications that the label on the Acetaminophen had 650mg instead of 500mg.
-The resident should have received Acetaminophen 500mg.

Observation of Resident #6's medications on hand on 05/21/25 at 10:18am revealed:
-There was an over-the-counter (OTC) bottle of Acetaminophen 650mg tablets for the resident.
-There was no prescription label with instructions on the bottle.
-There was no other supply of Acetaminophen on hand for the resident.

Interview with Resident #6 on 05/21/25 at 1:29pm 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 _____	R 05/21/2025

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 2	D 358		

-She took Acetaminophen for leg pain
-It sometimes helped with her pain and sometimes it did not help with pain.
-She was not sure what strength of Acetaminophen she usually received.

Interview with the Resident Care Coordinator (RCC) on 05/21/25 at 10:23am revealed:
-The MA on duty was responsible for checking medications provided by family members to make sure it matched the MARs.
-The MAs were supposed to read the medication labels and compare them to the MARs prior to administering medications.
-If there was a discrepancy with a medication, the MAs should notify her.
-She had not been notified of any concerns with Resident #6's Acetaminophen.

Interview with the Administrator on 05/21/25 at 1:21pm revealed:
-The RCC and MAs were responsible for checking any medications provided by family members.
-There was not currently a system to monitor medications provided by family members, but she planned to start one today.
-The MAs had been trained to compare medication labels and the MARs at least 3 times prior to administering medications to make sure they matched.

Attempted telephone interview with Resident #6's primary care provider (PCP) on 05/21/25 at 12:03pm was unsuccessful.

b. Review of Resident #7's current FL-2 dated 01/13/25 revealed:
-Diagnoses included neuropathy, bilateral carpal tunnel syndrome, impaired mobility, mixed

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 _____	R 05/21/2025

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 3	D 358		

hyperlipidemia, gastroesophageal reflux disease, and depression.
-There was an order for Acetaminophen 650mg 2 tablets every 12 hours for back pain. (Acetaminophen is used for mild to moderate pain.)

Review of Resident #7's primary care provider (PCP) visit note dated 02/25/25 revealed:
-The resident was being seen for a chronic care visit.
-The resident was in good, stable condition with no signs and symptoms of distress and no complaints of pain.
-The resident requested to stop scheduled Acetaminophen.
-The PCP noted she would change Acetaminophen to prn (as needed) per resident request.

Review of Resident #7's PCP orders dated 02/25/25 revealed:
-There was an order to discontinue the scheduled Acetaminophen.
-There was an order to start Acetaminophen 500mg 2 tablets every 8 hours as needed.

Observation of the 8:00am medication pass on 05/21/25 revealed:
-The medication aide (MA) prepared and administered two Acetaminophen 650mg tablets to Resident #7 at 7:41am when he received his other medications scheduled for 8:00am.
-The resident did not request Acetaminophen or complain of pain.
-The resident was administered two Acetaminophen 650mg tablets after the order had been discontinued.

Review of Resident #7's medication

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 _____	R 05/21/2025

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 4	D 358		

administration record (MAR) revealed:
-There was a computer-printed entry for Acetaminophen 650mg 2 tablets every 12 hours for back pain scheduled at 8:00am and 8:00pm.
-Acetaminophen 650mg was documented as administered from 05/01/25 - 05/21/25 (8:00am).
-There was a computer-printed entry for Acetaminophen 500mg 2 tablets every 8 hours as needed for pain; maximum dose of Acetaminophen from all sources 4,000mg/day.
-There was no Acetaminophen 500mg documented as administered.

Observation of Resident #7's medications on hand on 05/21/25 at 9:46am revealed:
-There was a supply of Acetaminophen 500mg tablets dispensed on 02/25/25.
-The instructions were to take 2 tablets every 8 hours as needed for pain; maximum dose of Acetaminophen from all sources was 4,000mg/day.
-There were 60 of 60 Acetaminophen 500mg tablets remaining.
-There was a new supply of Acetaminophen 650mg tablets in the batch supply of medications with a start date of 05/22/25.
-The instructions were to take 2 tablets every 12 hours for back pain.

Interview with the MA on 05/21/25 at 9:47am revealed:
-Resident #7 took Acetaminophen for neck and back pain.
-She administered two Acetaminophen 650mg tablets to Resident #7 because it was listed on the May 2025 MAR to be administered at 8:00am.
-She was not aware the order for scheduled Acetaminophen had been discontinued and changed to prn.
-The Resident Care Coordinator (RCC) usually

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 _____	R 05/21/2025

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 5	D 358		

reviewed the new computer-printed MARs received from the pharmacy each month for accuracy.

Interview with Resident #7 on 05/21/25 at 1:13pm revealed:
-He took Acetaminophen for body pain in the morning and at nighttime.
-He could also get Acetaminophen when he asked for it when he had headaches.
-He did not recall if the PCP had changed the Acetaminophen order.
-Acetaminophen usually helped with his pain.

Interview with the RCC on 05/21/25 at 10:26am revealed:
-The pharmacy usually input orders into the computer system that generated the facility's paper MARs, including removing any discontinued orders.
-She was responsible for faxing and emailing orders to the pharmacy.
-She checked the computer-printed paper MARs each month when they were received to make sure they MARs were accurate.
-She had marked off the scheduled entry for Acetaminophen on the February 2025 - April 2025 MARs as being discontinued.
-She probably overlooked the scheduled Acetaminophen entry on the May 2025 MAR but should have marked through it so the MAs would know the order had changed.

Interview with the Administrator on 05/21/25 at 1:21pm revealed:
-The RCC was responsible for reviewing the new MARs each month to make sure the entries were accurate.
-Any discontinued medication should be removed from the medication cart when it 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 _____	R 05/21/2025

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 6 discontinued to make sure it was not administered again. Attempted telephone interview with Resident #7's PCP on 05/21/25 at 12:03pm was unsuccessful.	D 358		