

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>345505</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED <b>01/21/2026</b>
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NAME OF PROVIDER OR SUPPLIER <b>Carolina Rehab Center of Cumberland</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4600 Cumberland Road , Fayetteville, North Carolina, 28306</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F0000	<p>INITIAL COMMENTS</p> <p>A complaint investigation was conducted on 1/20/26 and 1/21/26. The following intakes were investigated: 2717395, 2587951, and 2581217.</p> <p>One of seven complaint allegations resulted in deficiency.</p>	F0000		01/26/2026
F0759 SS = D	<p>Free of Medication Error Rts 5 Prcnt or More</p> <p>CFR(s): 483.45(f)(1)</p> <p>§483.45(f) Medication Errors.</p> <p>The facility must ensure that its-</p> <p>§483.45(f)(1) Medication error rates are not 5 percent or greater;</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, record review, and staff interviews the facility failed to ensure their medication error rate was less than 5%. Two (2) medication administration errors were detected out of 38 opportunities. The medication errors occurred for 2 of 3 residents observed during medication administration (Resident #8 and Resident #9). This resulted in a 5.26% medication error rate.</p> <p>The findings included:</p> <p>1a. On 1/21/26 at 9:12 AM Nurse #1 was observed as she prepared and administered morning medications to Resident #8. Nurse #1 was observed to remove two docusate sodium (stool softener) 100 mg (milligrams) capsules from a stock bottle and place them in a cup of medications she was preparing to administer for Resident #8. Nurse # 1 was observed to administer the two docusate sodium capsules to Resident #8. Nurse # 1 was not observed to administer any other type of stool softener to the resident.</p> <p>Resident #8's orders were reviewed following the medication administration observation for</p>	F0759	<p>The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility's allegation of compliance. All deficiencies cited have been or will be corrected by the date or dates indicated.</p> <p>F0759</p> <p>Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>The med cart (where the medication errors occurred) was reconciled with the residents' MAR for any discrepancies. The facility Medical Director was made aware of errors and reviewed all current medications for both residents. Residents #8 &amp; #9 were assessed for pain, discomfort, or injury related to medication error and noted to be unaffected and pain-free on 1/22/26 by the charge nurse and Unit Manager. Resident #8 was provided with a medication of self-administered screening and physician order was obtained for self-administration on 01/22/26.</p> <p>Address how the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <p>An audit of medication administration records (MARs) was conducted for all residents receiving medications</p>	02/02/2026

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F0759 SS = D	<p>Continued from page 1 reconciliation purposes. Resident #8 did not have an order for docusate sodium 100 mg. Resident #8 had an order, dated 5/29/25, for two tablets of sennosides docusate sodium (a combination medication with a bowel stimulant and a stool softener) 8.6-50 mg daily.</p> <p>On 1/21/26 at 10:35 AM orders were reviewed with Nurse #1, and Nurse #1 was interviewed about giving docusate sodium rather than the ordered sennosides docusate sodium to Resident #8. Nurse #1 reported she had not realized she had administered the wrong type of stool softener.</p> <p>1b. On 1/21/26 at 9:16 AM Nurse #1 was observed as she prepared and administered medications for Resident #9. Nurse #1 was observed to remove one tablet containing Calcium 600 mg with Vitamin D 5 micrograms (a calcium and vitamin supplement) from a stock medication bottle and place it in a medication cup. Nurse #1 was observed to administer the Calcium 600 mg with Vitamin D5 micrograms to Resident #9.</p> <p>Resident #9's orders were reviewed following medication observations for reconciliation purposes. Resident #9 had an order, dated 1/8/26, for calcium citrate 950 mg (200) one tab every day (The 200 indicates the amount of elemental calcium available for usage by the body which is separate from the weight of the calcium pill).</p> <p>On 1/21/26 at 10:35 AM orders were reviewed with Nurse #1, and she was interviewed about the difference in calcium supplement she had administered to Resident #9 versus the prescribed calcium supplement. Nurse # 1 reported the facility had only one dosage of calcium stocked and therefore she had given what the facility had in stock.</p> <p>An interview with the DON (Director of Nursing) on 1/21/26 at 2:35 PM revealed the following information. She (the DON) had reviewed Resident #9's record and it appeared Resident #9 took the prescribed dosage of Calcium at home prior to being hospitalized for supplementation and not for a specific diagnosis. The DON explained the daily calcium citrate 950 mg (200) one tab had then been ordered at the hospital and then also at the facility when the resident was admitted. The DON stated there had been no verification prior to the morning of 1/21/26 with the physician about the ordered calcium dosage versus what the facility had in stock with the physician.</p>	F0759	<p>Continued from page 1 on the affected unit to ensure no additional errors occurred on January 23, 2026. Over the counter medications on affected medication cart matches orders medications were reviewed for accuracy. No further discrepancies were noted.</p> <p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.</p> <p>A QAPI (Quality Assurance and Performance Improvement) plan was initiated on January 22, 2026. The following members were present: Administrator, DON, Activities Director, Medical Records, Business Office Manager, Central Supply, Dietary Manager, Maintenance Director, Staffing Coordinator, Director of Rehab, and Assistant Business Office Manager. On 1/22/2026, the QAPI team met and decided to initiate a corrective action plan.</p> <p>The SDC (Staff Development Coordinator) and DON began education for all licensed nurses and medication aides on the 6 rights of a Safe Medication Administration 1/22/26. The education topic included: The three checks when administering medication as well as 6 rights of medication administration. No one will be allowed to work until education is completed. The DON and Unit Managers will review 2 medication passes 2 times per week for 4 weeks, then 1 time per week for 4 weeks to ensure accuracy.</p> <p>4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.</p> <p>The DON and Unit Manager will review 2 medication passes 2 times per week for 4 weeks, then 1 time per week for 4 weeks to ensure accuracy beginning the week of January 25, 2026. The RDCS (Regional Director of Clinical Services) will ensure audits are completed weekly.</p> <p>The QAPI Committee will meet monthly review audits and make recommendations to ensure ongoing compliance is maintained.</p> <p>The QAPI Committee will determine the need for further intervention and auditing to ensure ongoing compliance is sustained ongoing.</p> <p>5. Completion Date 02/02/2026</p>	

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