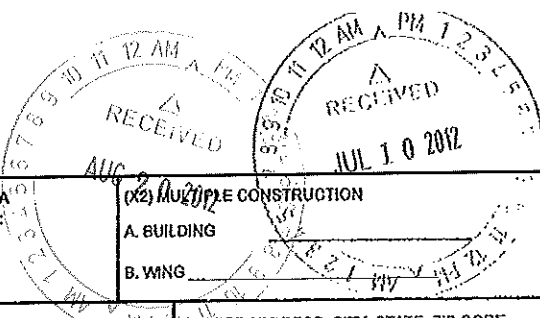


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/03/2012  
FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345409	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED  06/28/2012
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NAME OF PROVIDER OR SUPPLIER  PEMBROKE CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 310 E WARDELL DRIVE PEMBROKE, NC 28372
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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
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP  Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.  This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to serve Cole slaw at or below 40 degree Fahrenheit for 1 of 2 meal preparation observations. Findings include:  A review of the undated Facility Policy regarding 3-501.15 Cooling Methods, read as follows: " (A) Cooling shall be accomplished in accordance with the time and temperature criteria specified under § 3-501.14 by using one or more of the following methods based on the type of Food being cooled: (1) Placing the FOOD in shallow pan; (2) Separating the FOOD into smaller or thinner portions; (3) Using rapid cooling EQUIPMENT; (4) Stirring the FOOD in a container placed in an ice water bath; (5) Using containers that facilitate heat transfer; (6) Adding ice as an ingredient; or (7) Other effective methods.  During a kitchen observation on 6/28/12 at 9:00 AM, the cook was observed making Cole slaw for the noon meal. The cook was observed placing an approximate 12 inch by 24 inch long by 10 inch deep size pan into the reach in cooler at 9:10	F 364	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, <b>Pembroke Care and Rehabilitation Center</b> does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."  <u>Place your Plan of Correction here.</u> 1) All coleslaw was removed from the tray line and disposed by the Dietary Manager 6/28/12  2) Resident's lunch trays were observed for coleslaw collected and removed from trays by Dietary manager, Administrator, and floor staff 6/28/12.  3) Dietary staff were re-educated, on food cooling methods, food handling and acceptable, food temperatures by Certified Dietary Manager , Registered Dietician on 6/28/12.	7/3/12.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Theresa Johnson Telleson TITLE: Administrator (X6) DATE: 7/3/12

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 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 those documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER  PEMBROKE CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 310 E WARDELL DRIVE PEMBROKE, NC 28372	
(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)	(X6) COMPLETION DATE
F 364	Continued From page 1 AM.  During a second kitchen observation on 6/28/12 at 11:45 AM dietary staff were observed to transfer Cole slaw from the long pan into a smaller pan which was over ice and ready for noon service. At 11:50 AM the Certified Dietary Manager (CDM) calibrated a thermometer and checked the temperature of the Cole slaw. The Cole slaw pan over ice was observed to read 55 degree Fahrenheit.  During the kitchen observation at 11:55 AM the CDM revealed we use a cold pan. This pan should have been in the freezer before staff added the Cole slaw. At 12 noon the CDM was observed to calibrate a second thermometer and check the temperature of the Cole slaw. The Cole slaw over ice was observed to read 48 degree Fahrenheit and the puree Cole slaw read 40 degree Fahrenheit. The CDM then went to the freezer to check the temperature of the Cole slaw there, which read 55 degree Fahrenheit.  During the kitchen observation dietary staff were observed plating up both regular and puree Cole slaw and to place the completed meal trays into the dining cart. At 12:05 PM the thermometer resting in the Cole slaw over ice read as 48 degree Fahrenheit. At 12:08 PM nursing assistants were observed to push the dining cart from the kitchen to the 300 hall and begin to serve trays. The first resident served, declined her tray and staff were observed to return the untouched tray to the dining cart. At 12:10 PM the nursing assistant delivered a tray to a resident in the 300 hall dining room, removed the lid, left the dining room and continued on down the 300	F 364	4) The Certified dietary manager , RD or cook will complete daily food temperature audits of meals prior to tray service. The Administrator or designee will perform random audits 4 x weekly for 4 weeks then monthly x 2 to assure compliance. The Dietary Manager will submit the audit to the Performance Improvement Committee monthly x3 to monitor for compliance and any changes needed	

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NAME OF PROVIDER OR SUPPLIER  PEMBROKE CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 310 E WARDELL DRIVE PEMBROKE, NC 28372		
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F 364	Continued From page 2 hall to the next room.	F 364			
	<p>In an interview with the cook on 6/28/12 at 11:49 AM she stated, " I should have separated it all into smaller pans. "</p> <p>During an interview on 6/28/12 at 1:45 PM the Administrator stated, " There will be an In-service with all the staff regarding cold food temperatures this is too important for anyone to miss. "</p> <p>Interview with the CDM on 6/28/12 at 3:05 PM she stated. "Oh my staff know the correct food temperatures; I expect them to serve food at the proper temperature."</p>				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345409	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  07/18/2012
NAME OF PROVIDER OR SUPPLIER  PEMBROKE CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 310 E WARDELL DRIVE PEMBROKE, NC 28372	
(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
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1  This STANDARD is not met as evidenced by: A. Based on observation on 07/18/2012 both doors to the laundry were being held open and could not close upon activation of the fire alarm. B. Based on observation on 07/18/2012 the door to the Central Supply on the 400 hall failed to close and latch. C. Based on observation on 07/18/2012 the door to the Therapy Storage room failed to close and latch.	K 029	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Pembroke Care and Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."  1) The laundry room doors were closed on July 18 by the Maintenance Director. The door to Central Supply room and the therapy storage room were repaired to self close and latch by Maintenance Director, on July 18.  2) Doors were checked to ensure that the doors self closed and latched by the Maintenance Director on July 19th, 2012.  3) Staff were re-educated on reporting to Maintenance Director doors that do not self close or latch and not to prop doors on July 19 by Staff Development Coordinator	
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.  (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.  (b) Locations for supply systems of greater than	K 076		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Shirley Johnson-Tellison* TITLE *Administratrix* (X6) DATE *8/1/12*

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NAME OF PROVIDER OR SUPPLIER  PEMBROKE CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 310 E WARDELL DRIVE PEMBROKE, NC 28372		
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K 076	Continued From page 1 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4  This STANDARD is not met as evidenced by: A. Based on observation on 07/18/2012 there were O2 cylinders full and empty mixed and unsecured in the O2 storage room near room 112. 42 CFR 483.70 (a)	K 076	4) The Maintenance Director or designee will perform random audits 4 x weekly for 4 weeks then monthly x 2 months to assure compliance. The Maintenance Director will submit the audit to the Performance Improvement Committee monthly x 3 months to monitor for compliance and any changes needed  1) Full and empty O2 cylinders were separated on July 18 by the Maintenance Director. Any unsecured cylinders were secured by the Maintenance Director on July 18  2) Rooms storing O2 cylinders were inspected to ensure that the full and empty cylinders were separated and secured on July 18 by the Maintenance Director.  3) Staff was re-educated on storage, separating empty and full cylinders, and securing of O2 cylinders on July 19 by Staff Development Coordinator  4) The Director of Nursing or designee will perform random audits 4 x weekly for 4 weeks then monthly x 2 months to assure compliance. The Director Nursing will submit the audit to the Performance Improvement Committee monthly x 3 monitors to monitor for compliance and any changes needed  8/2/12	8/2/12	