STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345409	A. BUILDING _____ B. WING _____	C 05/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEMBROKE CENTER	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
E 000	Initial Comments An unannounced recertification/complaint investigation survey was conducted. The survey team was onsite 05/10/21 through 05/13/21. Additional information was obtained on 05/14/21 through 05/21/21. Therefore, the exit date was 05/21/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 7G4V11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification/complaint investigation survey was conducted. The survey team was onsite 05/10/21 through 05/13/21. Additional information was obtained on 05/14/21 through 05/21/21. Therefore, the exit date was 05/21/21. Event ID# 7G4V11. 4 of 25 complaint allegations were substantiated with deficiency, and 5 of 25 complaint allegations were substantiated without deficiency.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550		6/18/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/14/2021

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F 550	Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to treat a resident in a respectful and dignified manner for 1 of 1 residents (Resident #22) when Nursing Assistant (NA) #8 pointed at the resident and told him to get his a** back to his room. Findings included: Resident #22 was admitted to the facility on 06/27/18 and had diagnoses of dementia with behaviors, anxiety disorder, and major depressive disorder.	F 550	F550 Resident Rights 1. Corrective action. Nursing Assistant (NA) #8 is no longer employed at Genesis Healthcare Pembroke Center. 2. Others having the potential to be affected. All residents have the potential to be	

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F 550	Continued From page 2 The annual Minimum Data Set (MDS) dated 05/13/20 revealed that Resident #22 was severely cognitively impaired, had no behaviors and did not reject care. The written statement signed and dated by NA #8 on 05/18/20 revealed that he saw Resident #22 wheel himself into the hallway and said not too loudly "get your a** back in the room". The statement indicated that Resident #22 did not hear NA #8 and that he was speaking to his co-workers not to the resident. The written statement signed and dated by the Unit Manager (UM) on 05/18/20 revealed she overheard NA #8 say to Resident #22 to take your a** back to your room. The statement indicated that NA #8 pointed to Resident #22's room and although the resident did not respond verbally, he did go back to his room. According to the statement, the UM informed NA #8 that he could not speak to residents that way and informed him that he needed to leave the facility. She reported the incident to the Director of Nursing (DON) who then notified the Administrator. The written statement signed and dated by NA #9 on 05/18/20 revealed she had been standing at the nurse's station waiting to receive her assignment. The statement indicated she heard NA #8 tell Resident #22 to get his a** back into his bedroom because he was coming out of his room into the hallway. The statement indicated that Resident #22 returned to his room. The written statement signed and dated on 05/18/20 by NA #5 indicated that she overheard NA #8 tell Resident #22 to take his a** back to his room.	F 550	affected. Center Executive Director and Social Services Director to interview Alert and Oriented Residents regarding Resident Rights. 3. What measures will be put in place or what systemic changes? All facility staff including contracted facility staff, will be educated on Residents Rights under Federal law 483.10 and facility policy OPS213 Treatment: Considerate and Respectful by the Director of Social Services per facility policy SS110 Residents□ Rights: Role of Social Services and/or designee. Education will be completed by 06/18/2021. 4. Monitoring of corrective action. 5 random audits of staff interaction with residents will be conducted weekly x4 weeks; bi-weekly x4 weeks; monthly x2 months by Director of Social Services and/or designee. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance. Director of Social Services will be responsible for the implementation of this plan.	

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F 550	Continued From page 3	F 550		

In a telephone interview on 05/14/21 at 9:09 AM NA #8 stated that this incident happened about a year ago and he denied that he told Resident #22 to get his a** back to his room. NA #8's written statement was read to him and then he confirmed that he did say it but not loudly and that no one heard him. He stated that he did not say it to Resident #22 to be mean and did not say it in a mean way.

In a telephone interview on 05/14/21 at 1:26 PM the UM stated she heard NA #8 tell the resident to go back to his room and pointed at the room. She indicated that Resident #22 reacted by turning around and going back to his room which showed that he heard what NA #8 said. She stated that she spoke with NA #8 and he denied telling the resident to get his a** back to his room. She indicated that NA #8 was sent home and did not work in the facility again. The UM stated that she reported the incident to the DON right away.

In a telephone interview on 05/14/21 at 1:59 PM NA #5 stated she had just started her shift and was standing at the nurse's station with NA #8. She indicated that Resident #22 came out of his room and NA #8 told him "you know you need to take your a** back in your room." She indicated the UM talked with NA #8 and made him leave the facility.

In a telephone interview on 05/17/21 at 1:32 PM the DON stated that she expected staff to treat residents with respect and dignity at all times. She indicated that staff should not use inappropriate language to residents when speaking with them.

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F 578	Continued From page 4	F 578		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he	F 578		6/14/21

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F 578	Continued From page 5 or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to verify and obtain a physician's order for a resident's advanced directives for 1 of 25 residents (Resident #116) reviewed for advanced directives. The findings included: Resident #116 was admitted to the facility on 04/28/21 with diagnoses which included: anoxic brain damage, coronary artery disease (CAD), myocardial infarction (MI), hypertension (HTN), and diabetes (DM). A review of Resident #116's Electronic Medical Record (EMR) revealed no physician's order to establish the resident's code status. Further review of Resident #116's EMR revealed there were no indications of an Advanced Directive on the resident's profile page or on the resident's face sheet. A review of Resident #116's five-day Minimum Data Set (MDS) dated 05/05/21 revealed Resident #116 had severe cognitive impairments. The care plan dated 05/05/21 for Resident #116 was reviewed on 05/10/21 and there was no information contained in the resident's care plan, or focus areas, regarding the resident's code status.	F 578	F578 Request/Refuse/Discontinue Treatment 1. Corrective Action. Resident #116□s attending physician confirmed the wishes regarding code status on 5/13/21. Electronic chart reviewed and updated to reflect the wishes regarding code status by Nurse Practice Educator (NPE) on 5/13/2021. Full Code Electronic Order entered on 5/13/2021. Care plan reviewed and reflected current code status on 5/13/21. 2. Others having the potential to be affected. All residents have the potential to be affected. Advance directive validation audit of current residents was completed by Center Nurse Executive (CNE) and Center Executive Director (CED) on 6/2/2021. 3. What measures will be put in place or what systemic changes? Education provided to all licensed nursing staff on facility policy OPS422 Code Status Orders by the CNE and/or designee to be completed by 06/14/21. To ensure 100% compliance, no licensed	

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F 578	Continued From page 6 An interview was conducted on 05/13/21 at 12:13 with the Nurse Practice Educator. She said sometimes she will enter a resident's code status and sometimes the nurse who admitted the resident, or writes the code status order, will put the code status into the resident's EMR. She reviewed the resident's EMR, paper chart, including the resident's orders, and stated she did not see the resident's code status order in the resident's EMR or paper chart. A follow-up interview was conducted on 05/13/21 at 12:30 PM with the Nurse Practice Educator. She believed Resident #116 was a full code based on his hospital paperwork. She reviewed the resident's physician's orders and stated she did not see the resident's code status in the physician's orders or documented elsewhere in the resident's EMR or paper chart. She reviewed the resident's hospital History and Physical (H&P) and the resident was a full code at the hospital and a full code order should have been written at the facility to establish the resident's code status in the resident's EMR. She stated if the resident were to be in an emergency the facility would treat the resident as a full code, even if the resident or the family wished otherwise. The Nurse Practice Educator stated she would immediately contact Resident #116's physician to obtain a code status order and would place resident's code status in his EMR. An interview was conducted on 05/13/21 at 12:42 PM with the Director of Nursing (DON). The DON stated it was her expectation for each resident to have an order for their desired advance directive and for Resident #116's advance directive to be documented in the resident's EMR.	F 578	nursing staff member will be permitted to return to work until mandatory in-service completed by 06/14/21. For new admissions and readmissions, The Social Services Director (SSD) and/or licensed nurse will review the advance directive with the family and/or resident. The completed advance directive will be given to the social services director and the CNE. The social services director will place the advance directive paperwork in the Medical Director (MD) box for signature. The CNE and/or licensed nurse will communicate the request on the advance directive with the MD to obtain an order. The order will then be placed in the residents medical record. Social Services Director (SSD), Minimum data set (MDS) nurse and/or licensed nurse will update resident care plan to reflect current advance directives decisions. The interdisciplinary team (IDT) will discuss and verify the status of the advance directive during each resident and/or family meeting. 4. Monitoring of corrective action. The Center Nurse Executive (CNE) or Social Services Director (SSD) will audit all new admit/readmit,(Monday to Friday to include Saturday/Sunday) weekly x4 weeks, starting 6/14/2021, then monthly x2 months to validate that the advance directive and Physician Orders are in place and reflecting the correct information.	

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F 578	Continued From page 7 An interview was conducted on 05/13/21 at 12:50 PM with the Administrator. The Administrator said each resident's advanced directives and code status was required as soon as possible as part of the patient's admission order set, that staff should have verified Resident #116's wishes with regard to code status (Full Code vs. DNR) upon admission.	F 578	Results of these audits will be brought before the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and performance Improvement Committee can modify this plan to ensure the facility remains in compliance. Social Services Director, Center Nurse Executive, and Center Executive Director are responsible for implementation of the plan.	
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and Registered Dietician (RD) and staff interviews, the facility failed to clarify the amount of a liquid supplement provided to improve nutritional status and failed to follow the physician's order to place sheepskin on the bolsters to protect fragile skin for 1 of 25 residents (Resident #47) whose orders were reviewed. Findings included: 1a. Resident #47 was admitted to the facility on 05/04/16 and had diagnoses of dementia without behaviors, severe protein-calorie malnutrition and Adult Failure to Thrive (AFTT). The Care Plan created 05/11/16 revealed that	F 658	F658 Services Provided Meet Professional Standards 1. Corrective Action. Resident #47 order for Med Pass was clarified by Unit Manager (UM) and transcribed accurately in resident electronic chart on 05/13/21. Sheepskin put in place on bolsters by Maintenance Director, for what resident #47 at request of UM, per MD order on 05/13/21. 2. Others having the potential to be	6/18/21

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F 658	Continued From page 8 Resident #47 was on a mechanically altered diet and received supplements to improve her nutritional status. The Care Plan contained an intervention for Med Pass (a nutritional supplement) bid (twice each day) that was initiated on 03/22/21. The quarterly Minimum Data Set (MDS) dated 04/22/21 revealed that Resident #47 was severely impaired in cognitive skills for daily decision making and was dependent on one person for eating. The Healthcare Food and Nutrition Services Nutritional Care Recommendations dated 01/21/21 and signed by the RD, revealed she recommended a trial of 60 ml (milliliters) of Med Pass twice a day for continued significant weight loss and an extremely low Body Mass Index (BMI) for Resident #47. The Physician Order dated 01/25/21 revealed an order for Med Pass to be provided two times a day. There was no amount to show how much Med Pass should be administered. The January 2021 Medication Administration Record (MAR) revealed that Med Pass two times a day was to start on 01/25/21 for Resident #47 and be administered at 9:00 AM and 5:00 PM. There was no amount provided for the liquid Med Pass. Out of the 6 opportunities in January 2021 at 9:00 AM 30 ml was administered 5 times and 60 ml was administered 1 time. Out of the 7 opportunities in January 2021 at 5:00 PM 30 ml was administered 3 times and 60 ml was administered 4 times. The February 2021 MAR revealed that Med Pass	F 658	affected. All residents with nutritional/hydration management per Registered Dietician (RD) recommendations and residents with the need for special devices, have the potential to be affected. Complete special equipment/device audit on all current residents completed by CNE/ACNE and/or designee on 06/11/21. Complete audit of Nutritional Care Recommendations for past 30 days completed by CNE/ACNE and/or designee on 06/11/21. No additional concerns noted. 3. What measures will be put in place or what systemic changes? Education provided to all licensed nursing staff on facility policy NSG223 Nutrition/hydration management, NSG113 Nursing Documentation, NSG117 Transcription of orders, NSG251 24-hour Chart Check, and NSG305 Medication Administration: General by Center Nurse Executive (CNE), Assistant Center Nurse Executive (ACNE) and/or designee. Education completed by 6/18/21. To ensure 100% compliance in meeting professional standards, no licensed nursing staff member will be permitted to return to work until mandatory in-service completed on 06/18/21. The Registered Dietician (RD) will place a copy of Nutritional Care Recommendations in physicians□ box,	

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F 658	Continued From page 9 was to be administered twice a day at 9:00 AM and 5:00 PM to Resident #47. There was no amount provided for the liquid Med Pass. Out of the 28 opportunities at 9:00 AM zero Med Pass was administered 6 times, 30 ml was administered 15 times, 50 ml was administered 8 times and 60 ml was administered 5 times. Out of the 28 opportunities at 5:00 PM zero Med Pass was available 2 times, an unknown code was used 1 time with no explanation of what the code meant, 30 ml was administered 5 times, 50 ml was administered 5 times, 60 ml was administered 12 times, and 100 ml was administered 3 times. The March 2021 MAR revealed that Med Pass was to be administered to Resident #47 twice a day at 9:00 AM and 5:00 PM. There was no amount provided for the liquid Med Pass. Out of the 31 opportunities at 9:00 AM 30 ml was administered 16 times, 50 ml was administered 3 times, 60 ml was administered 10 times and 90 ml was administered 2 times. Out of the 31 opportunities at 5:00 PM zero Med Pass was available 1 time, 30 ml was administered 15 times, 50 ml was administered 8 times and 60 ml was administered 7 times. The April 2021 MAR revealed that Med Pass was to be administered to Resident #47 twice a day at 9:00 AM and 5:00 PM. There was no amount provided for the liquid Med Pass. Out of the 30 opportunities at 9:00 AM a code showing "in progress" was used once, 50 ml was administered 15 times and 60 ml was administered 14 times. Out of the 30 opportunities at 5:00 PM a code showing "in progress" was used once, 50 ml was administered 14 times and 60 ml was	F 658	CNE box and MDS Nurse box after nutritional assessments per state and facility guidelines have been completed. 4. Monitoring of corrective action. The CNE, ACNE and/or designee will audit all RD recommendations per physician approval and orders for special devices/equipment for accuracy of orders entered on residents Electronic Medical Record (eMAR) weekly to include eMAR documentation for accuracy x4 weeks (starting 6/18/2021) then monthly x2 months to validate accuracy and reflect in resident self-centered care plan. Results of these audits will be brought before the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and performance Improvement Committee can modify this plan to ensure the facility remains in compliance. The facility Center Nurse Executive will be responsible for implementation of the plan.	

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F 658	Continued From page 10	F 658		

administered 15 times.

The May 2021 MAR revealed that Med Pass was to be administered to Resident #47 twice a day at 9:00 AM and 5:00 PM. There was no amount provided for the liquid Med pass. Out of 13 opportunities 50 ml was administered 11 times, 90 ml was administered 1 time and 100 ml was administered 1 time. Out of the 12 opportunities at 5:00 PM Med pass was unavailable 1 time, 50 ml was administered 10 times and 90 ml was administered 1 time.

In an interview on 05/13/21 at 11:00 AM the RD stated that the Med Pass order was incomplete because it did not contain the amount of Med Pass to administer to Resident #47. She indicated that the order should have been clarified with her or Resident #47's physician to see what amount needed to be administered. The RD stated that no one had asked her to clarify the amount of Med Pass that Resident #47 was to receive. She indicated that a nurse should not give just any amount they wanted because it was an intervention for weight loss and poor oral intake and needed to be monitored for effectiveness. The RD stated that the purpose of Med Pass for Resident #47 was to provide extra calories and protein. She indicated that Resident #47 was only eating sweet things now and that Med Pass was sweet. She stated that Resident #47 had weight loss in January 2021 and that was why the Med Pass was started. She indicated that Resident #47's weight was stable at this time and that she had even gained a little weight.

In an interview on 05/13/21 at 3:58 PM Nurse #9, who administered Med Pass to Resident #47

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	345409	A. BUILDING _____ B. WING _____	C 05/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 658	Continued From page 11	F 658		

multiple times from 01/25/21-05/12/21, reviewed the Med Pass order on the MAR and stated that the nurse would not know how much Med Pass to administer. She indicated that the order should have been clarified because the nurse could not just give any amount. Nurse #9 indicated that she had not called the physician or the RD to clarify the order.

In a telephone interview on 05/15/21 at 11:32 AM Nurse #7, who administered Med Pass to Resident #47 twice in April 2021 stated that if the amount to administer was not listed on the MAR the order should be clarified. She indicated that she had not clarified the order prior to administering the Med Pass to Resident #47.

In a telephone interview on 05/16/21 at 2:31 PM Nurse #6, who administered Med Pass to Resident #47 multiple times from 03/01/21-05/13/21, stated that the amount of Med Pass would be listed on the MAR. She indicated that if the amount was not listed then the order should be clarified before administering it. Nurse #6 indicated that she had not spoken with the physician or the RD to clarify the order.

In a telephone interview on 05/17/21 at 1:32 PM the Director of Nursing (DON) stated that if there was a question about an order such as no amount of Med Pass to be given, she expected the nurse to clarify the order prior to administering it. She indicated that the nurse could not just give any amount they chose.

1b. The Care Plan created 01/11/19 and revised on 04/23/21 revealed that Resident #47 was at risk for bruising and skin tears. An intervention of sheepskin to bolsters (pillows that offer support

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345409	A. BUILDING _____ B. WING _____	C 05/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 658	Continued From page 12	F 658		

and protection) was initiated on 04/23/21.

The Physician Order dated 10/06/20 revealed sheepskin needed to be on Resident #47's bolsters every shift.

The quarterly Minimum Data Set (MDS) dated 04/22/21 revealed that Resident #47 was severely impaired in cognitive skills for daily decision making and needed the extensive assistance of two staff members for bed mobility and was dependent on two staff members for dressing, toilet use, hygiene and bathing.

The Treatment Administration Record (TAR) dated 05/09/21, 05/10/21, 05/11/21, and 05/12/21 revealed sheepskin to bolsters had been signed off as administered (completed) each shift.

In an observation on 05/10/21 at 3:17 PM bolsters were on Resident #47's bed but there was no sheepskin covering them.

In an observation on 05/10/21 at 5:01 PM bolsters were on Resident #47's bed but there was no sheepskin covering them.

In an observation on 05/11/21 at 1:40 PM bolsters were on Resident #47's bed but there was no sheepskin covering them.

In an observation on 05/11/21 at 5:41 PM bolsters were on Resident #47's bed but there was no sheepskin covering them.

In an observation and interview on 05/12/21 at 10:23 AM there was no sheepskin on the bolsters on Resident #47's bed. The Hospice Aide, who worked with Resident #47 Monday-Friday except

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345409	A. BUILDING _____ B. WING _____	C 05/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 658	Continued From page 13	F 658		

holidays and was there to work with the resident that day, stated she had not seen any sheepskin on Resident #47's bolsters and that usually they were just covered with the fitted bed sheet.

In a telephone interview on 05/13/21 at 5:17 AM Nurse #4, who worked with Resident #47 on the 3:00 PM-11:00 PM shift and the 11:00 PM-7:00 AM shift on 05/09/21, stated that she would have to pull up the sheet on the bed to see if the sheepskin had been in place and she did not recall doing that. She indicated she did not recall there being sheepskin on the bolsters for Resident #47.

In an observation on 05/13/21 at 8:29 AM there were bolsters on Resident #47's bed but there was no sheepskin on the bolsters.

In an observation and interview on 05/13/21 at 10:29 AM the Maintenance Director was in Resident #47's room and sheepskin was now on the bolsters. He indicated that the Unit Manager (UM) had requested he apply new bolsters and to place sheepskin on the bolsters that morning.

In an interview on 05/13/21 at 12:32 PM the UM stated that it was a problem that the nurses were signing off on the TAR for things that were not in use for the resident. She indicated that a nurse should not sign off for something before she completed the task. The UM indicated that she saw there was no sheepskin on Resident #47's bolsters and asked the Maintenance Director to apply it. She stated that Resident #47 had sheepskin before and did not know how long the bolsters had been without it.

In a telephone interview on 05/16/21 at 2:31 PM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345409	A. BUILDING _____ B. WING _____	C 05/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 658	Continued From page 14	F 658		

Nurse #6, who signed that sheepskin was in place for Resident #47 on the 7:00 AM-3:00 PM shift on 05/10/21, stated that she signed off tasks at the end of her shift as per how she remembered it. She stated that she should not sign anything off on the TAR without first making sure it was in place.

In a telephone interview on 05/16/21 at 2:54 PM Nurse #9, who signed that sheepskin was in place for Resident #47 on the 3:00 PM-11:00 PM and the 11:00 PM-7:AM shifts on both 05/10/21 and 05/12/21, stated that items that were to be checked off every shift "popped up" on the computer at the beginning of the shift. She indicated that gave the nurse the whole shift to check to see if the item was in place. She stated that she thought the sheepskin had been in place but that she could have signed off that it was in error.

In a telephone interview on 05/16/21 at 3:07 PM Nurse #3, who signed that sheepskin was in place for Resident #47 on the 7:00 AM-3:00 PM shift on 05/12/21, stated that she had been assisting another nurse on that shift and the nurse left without signing off the sheepskin. She indicated she just signed the item off so the task would change from red and that she did not go down and check to see if the sheepskin was in place.

In a telephone interview on 05/17/21 at 1:32 PM the DON stated it was her expectation that nurses not sign off every shift orders on the TAR until they were complete. She indicated the nurse should either inform the oncoming nurse in report or notify her (the DON) if something still needed to be done. She indicated that if a nurse signed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345409	A. BUILDING _____ B. WING _____	C 05/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 658	Continued From page 15 off that sheepskin was in place, they should have checked to make sure it was in place and if not, they should have put the sheepskin on the bolsters and then signed off the TAR.	F 658		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and Physician, Urology nurse, and staff interviews the facility failed to obtain and monitor blood sugar (BS) levels and failed to obtain laboratory results which caused a delay in treatment for 1 of 1 residents (Resident #171) which resulted in the resident being admitted to the hospital for Diabetic Ketoacidosis (high blood sugar) and a Urinary Tract Infection (UTI). Findings included: The Care Plan created 04/14/20 revealed that Resident #171 had diabetes. Interventions included to access and record blood sugar levels as ordered, to obtain laboratory work as ordered and to report the results to the physician, and to monitor any signs and symptoms of infection. The Care Plan created 08/06/20 revealed that Resident #171 required an indwelling supra pubic catheter. It was initiated on 03/11/21 that	F 684	1. Corrective action Resident #171 discharged facility on 4/23/2021 to another SNF. 2. Others having the potential to be affected All residents with diagnosis of Diabetes and laboratory orders have the potential to be affected. All current residents with a diagnosis of Diabetes orders audited by Center Nurse Executive (CNE), Assistant Center Nurse Executive (ACNE) and/or designee to ensure all components of a medication order; to include all insulin orders and blood sugar monitoring are accurate and in place. Complete audit of all ordered	6/18/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345409	A. BUILDING _____ B. WING _____	C 05/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 684	Continued From page 16 Resident #171 had been to the urologist that day and the suprapubic catheter was changed. An intervention of obtaining a urinalysis and culture and sensitivity (UA C&S) was recommended. There was also an intervention of monitoring labs as ordered on the Care Plan. The electronic Blood Sugar (BS) record revealed Resident #171 had a BS of 88 on 02/09/21. The next BS reading was recorded as 145 on 03/26/21. There were no BS readings listed between those dates. Resident #171 was readmitted to the facility from the hospital on 02/22/21 and had diagnoses of diabetes mellitus, neurogenic bladder with suprapubic catheter placement, Chronic Obstructive Pulmonary Disease (COPD) and a Urinary Tract Infection (UTI). The 02/22/21 orders revealed that Resident #171 was to use a Breo Ellipta inhaler (a steroid) every day for shortness of breath. Resident #171 was also ordered Novolog insulin to be injected on a sliding scale subcutaneously as needed. The parameters for administration of the insulin were: if BS was between 201-250 administer 2 units of insulin, if BS was between 251-300 administer 4 units of insulin, if BS was between 301-350 administer 6 units of insulin, if BS was between 351-400 administer 8 units of insulin, and if BS was greater than 400 administer 10 units of insulin and call the physician. The order did not direct how often to monitor Resident #171's BS. The Medication Administration Record (MAR) for 02/22/21-03/23/21 revealed no documentation that BS monitoring had been completed or that any sliding scale insulin (SSI) had been administered.	F 684	labs for the past 30 days for accurate laboratory process per facility policy was completed on 6/15/2021by CNE, ACNE and/or designee. No additional concerns noted. 3. What measures will be put in place or what systemic changes Education provided to all licensed nursing staff, including PRN and contracted staff on; Diabetes management to include components of an accurate order and blood sugar monitoring by CNE, ACEN and/or Designee. Education also included facility policy regarding Laboratory process by CNE, ACNE and/or designee, completed on 06/14/2021. 4. Monitoring of corrective action The CNE, ACNE and/or designee will audit all new medication orders and New Admissions/Readmissions will be reviewed for accuracy, to include all components of a drug order. Audit Conducted daily, (Monday to Friday to include Saturday/Sunday) x4 weeks, starting 6/14/2021, then monthly x2 months. The CNE, ACNE and/or designee will audit Labs to ensure the facility policy for the laboratory process have been followed. Audit Conducted daily, (Monday to Friday to include Saturday/Sunday) x4 weeks, starting 6/14/2021, then monthly x2 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345409	A. BUILDING _____ B. WING _____	C 05/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 684	Continued From page 17 The 02/23/21 orders revealed that Resident #171's insulin was changed from Novolog to Humalog insulin with the same parameters. The order did not list how often to monitor Resident #171's BS. The Physician's Progress Note dated 02/23/21 revealed Resident #171 was being seen by the physician after readmission to the facility from the hospital for a UTI. The plan was to continue and complete the course of antibiotic therapy. In addition, the plan was to monitor Resident #171's BS and adjust the medication as indicated. The 5-day Minimum Data Set (MDS) dated 03/01/21 revealed that Resident #171 was moderately impaired in cognitive skills for daily decision making. The resident had behavioral symptoms directed toward others 1-3 days but did not reject care. Resident #171 needed the extensive assistance of one staff member for bed mobility and was dependent on one staff member for dressing, hygiene and bathing and needed the extensive assistance of one staff member for toilet use. The resident had an indwelling catheter. Resident #171 received no injections and no insulin during the seven day look back period. The Urologist Report of Consultation dated 03/11/21 revealed that Resident #171 had his suprapubic catheter changed in the office. Resident #171 became agitated when the catheter was removed and upon reinsertion of the catheter. The Urologist requested urine be obtained for a culture and sensitivity. The 03/11/21 MAR revealed that a UA C&S was	F 684	Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly for 3 months. The Quality Assurance and Performance Improvement Committee can modify this plan to ensure the facility remains in compliance. The QAPI Committee responsible for ongoing compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345409	A. BUILDING _____ B. WING _____	C 05/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEMBROKE CENTER	310 E WARDELL DRIVE PEMBROKE, NC 28372

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F 684	Continued From page 18	F 684		

collected at the facility at 6:13 PM by Nurse #8.

The urine culture final result dated 03/14/21 at 7:12 AM revealed a diagnosis of a UTI from a voided urine sample. The colony count was >100,000 CFu/mL (Colony Forming units/milliliter). There were multiple Gram-Negative Bacilli present- 3 or more non-predominant species. It was noted that "the presence of three or more species of bacteria suggests contamination. If a repeat culture is indicated, please submit a clean catch or catheterized specimen." The laboratory results revealed the specimen taken date was 03/11/21 at 6:13 PM. The specimen was received in the lab on 03/12/21 at 6:40 PM (greater than 24 hours after obtaining) and resulted on 03/14/21 at 7:12 AM. The facility was unable to provide any follow-up on this lab result.

The 03/24/21 e-MAR (electronic-Medication Administration Record) Progress Note documented at 9:39 AM, revealed Nurse #6 notified the physician that Resident #171's BS would not read on the meter and she was instructed to administer 20 units of insulin. The Change in Condition Evaluation dated 03/24/21, and documented by Nurse #6, revealed that Resident #171 experienced a hyperglycemic (high BS) episode that started the morning of 03/24/21. The assessment revealed that the last BS taken was 02/09/21 and was 88. There were no mental or functional status changes. The physician was notified and an order to give 20 units of insulin with fluids was received. Hourly BS testing was also to be done.

The 03/24/21 MAR revealed the box for BS contained "NA" (not applicable) instead of a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345409	A. BUILDING _____ B. WING _____	C 05/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEMBROKE CENTER	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
F 684	Continued From page 19	F 684		

number and in the PRN (as needed) box was a "U" signifying unknown for how many units of insulin was given. There was no documentation that 20 units of insulin was administered to Resident #171 prior to transfer to the Emergency Department (ED) or that hourly BS readings were done.

The Hospital Emergency Department (ED) lab results revealed that Resident #171 had a glucose level of 568 mg/dL (milligrams/deciliter) and a Hemoglobin A1C of 9.6.

The Hospital Internal Medicine Progress Note dated 03/25/21 revealed that Resident #171 presented with Mild Diabetic Ketoacidosis (DKA) when admitted on 03/24/21. His BS level was improving and the BS reading that morning was 336.

The 03/26/21 Hospital Discharge revealed primary discharge diagnoses of hyperglycemia and catheter associated UTI. During the hospital admission Resident #171 required intravenous (IV) antibiotics, IV fluids, and IV insulin.

In a telephone interview on 05/16/21 at 2:31 PM Nurse #6, who was assigned to care for Resident #171 when he was sent to the hospital on 03/24/21, stated she could not remember what was going on with Resident #171 on the morning of 03/24/21. She indicated that something did not seem right with the resident and that she asked another nurse to come into the room. Nurse #6 indicated that she thought it was Nurse #3 who came into the room and suggested she check Resident #171's BS. She stated that she had not received any information in report that Resident #171 was acting any differently than he usually

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345409	A. BUILDING _____ B. WING _____	C 05/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 684	Continued From page 20	F 684		

did. Nurse #6 stated she injected 20 units of "whatever type of insulin was in the medication cart for him" to the resident. She indicated she did not document that the insulin was administered because she thought someone else was going to do that as she was busy. Nurse #6 stated she took BS readings several times that morning and it kept reading "high" instead of providing a number. She indicated that the family decided to send Resident #171 to the hospital after being informed about what was going on. Nurse #6 stated that in order to tell how much SSI to administer to a resident she would need to know what their BS was. She indicated that to know what the BS reading was she would have to test the resident's blood. Nurse #6 stated that BS should be checked as often as the order said and if it was not listed than the physician should be called, and the order clarified. She indicated that she had not called the physician to clarify the SSI order.

In a telephone interview on 05/16/21 at 3:07 PM Nurse #3 confirmed that she had helped Nurse #6 with Resident #171 on 03/24/21. She indicated that she could not really remember what had been happening with Resident #171 but that he seemed fatigued, sedated, and weak. Nurse #3 stated they took Resident #171's BS and it read "High." The physician was notified and a new order for insulin administration was received. She indicated she did not document that the insulin was administered. Nurse #3 stated that BS should be taken before meals and should be included on the order. She indicated that if it was not on the order you would not know how much SSI to give. Nurse #3 indicated that the order should have been clarified to see when the physician wanted Resident #171's BS to be taken

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345409	A. BUILDING _____ B. WING _____	C 05/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEMBROKE CENTER	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
F 684	Continued From page 21	F 684		

for monitoring. She indicated that she had not called the physician to clarify how often Resident #171's BS was to be monitored.

In a telephone interview on 05/16/21 at 3:29 PM Nurse #1, who worked with Resident #171 on 03/23/21 on the 7:00 AM-3:00 PM shift and the 3:00 PM-11:00 PM shift stated that Resident #171 was not sedated when he worked with him. He indicated that Resident #171 did not complain of thirst and that he could eat whatever he wanted. Nurse #1 stated that if a resident was on SSI then BS needed to be checked. He stated that if the nurse did not know the BS reading, they would not know how much SSI to give. Nurse #1 indicated that normally BS for SSI was checked before meals but if it was not on the order, the order should have been clarified. He indicated that he had not called the physician to clarify how often Resident #171's BS needed to be monitored.

In a telephone interview on 05/17/21 at 11:17 AM Nursing Assistant (NA) #7, who worked with Resident #171 on the 11:00 PM-7:00 AM shift on 03/23/21, stated that she did not recall that night.

In a telephone interview on 05/17/21 at 11:32 AM Nurse #7, who was assigned to Resident #171 on 03/23/21 on the 11:00 PM-7:00 AM shift, stated she remembered Resident #171 but not the night in question.

In a telephone interview on 05/17/21 at 1:32 PM the Director of Nursing (DON) stated that if a resident was ordered SSI, she expected BS to be monitored as per the order. She indicated that if the order did not include times to monitor the BS, such as before meals, the physician would need

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345409	A. BUILDING _____ B. WING _____	C 05/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 684	Continued From page 22	F 684		

to be called and the order clarified. She indicated that any type of steroid or an active infection could increase a resident's BS which would make BS monitoring that much more important. The DON indicated that she felt the monitoring of Resident #171's BS was just left off the order, was not clarified, and was just an error. She stated that the urine for the UA C&S that the Urologist ordered on 03/11/21 was sent from his office to the lab and not completed at the facility as documented on the March 2021 MAR by the nurse. The DON indicated that the facility had not received a report of Resident #171's UA C&S from the lab and had not been contacted by the urology office for any medications that may have been needed as a result of the urine testing or if a new specimen needed to be sent. The DON indicated that she felt that if Resident #171's BS had been monitored; he probably would not have had to be admitted to the hospital for high BS with a diagnosis of DKA.

In a telephone interview on 05/17/21 at 1:59 PM Resident #171's Physician stated that BS monitoring for SSI should be performed before meals and at bedtime. He indicated that if the times for monitoring were not included in the order, that someone should have called him to clarify the order. The physician indicated that he would be okay with the Urologist ordering a UA C&S but would expect the Urologist to make the physician aware of the results so he could decide on a course of treatment. He indicated he could not recall if he had been informed of the results of Resident #171's 03/11/21 UA C&S by either the facility or the Urologist. The Physician indicated that he expected his orders to be followed and if there were any questions he should be notified, and the orders clarified. He indicated that an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345409	A. BUILDING _____ B. WING _____	C 05/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEMBROKE CENTER	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
F 684	Continued From page 23 active infection such as a UTI or taking steroids of any kind could increase BS levels and monitoring the BS levels would be even more important. He stated that if monitoring of BS was not done it was a significant problem and probably contributed to Resident #171 being sent out to the hospital and being diagnosed with a UTI and DKA. In a telephone interview on 05/21/21 at 11:35 AM Nurse #8, who initialed the 03/11/21 MAR that the UA C&S was completed at 6:13 PM by her, stated that she no longer worked at the facility, had no access to Resident #171's medical record, and did not remember anything about a urine sample. In a telephone interview on 05/21/21 at 11:56 AM the Urology Nurse stated that Resident #171 came in for a catheter change on 03/11/21. She indicated that the urine sample was collected from the catheter in the office. The Urology Nurse stated that the process was for the office nurse to call the facility and let them know if the Urologist wanted to order a medication or if he wanted the sample to be recollected for some reason. When asked, the Urology Nurse indicated that she did not know if the facility had been notified of the result of the urine culture or if the Urologist had seen the results. She indicated she did not know if the Urologist wanted the sample recollected or if he wanted to order a medication for the UTI. She indicated she would find out the information and call back. A request to speak with the Urologist was made and was not acknowledged. No further information from the Urology practice was received.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		6/14/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345409	A. BUILDING _____ B. WING _____	C 05/21/2021

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F 689	Continued From page 24 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to provide safety interventions as ordered for 2 of 5 residents (Resident #47 and Resident #9) who were reviewed for accidents. Findings included: 1. Resident #47 was admitted to the facility on 05/04/16 and had diagnoses of dementia without behaviors, anxiety disorder, and acute kidney failure. Resident #47 had a history of falls. The Care Plan created 05/04/16 revealed that Resident #47 was at risk for falls and was revised on 05/11/21 to show that Resident #47 had a fall without injury on 05/09/21. The Care Plan contained an intervention of a fall mat at the bedside that was revised on 02/26/21. The printed Kardex Report dated 04/22/20 which was hanging on Resident #47's closet and had been updated by hand, listed falls mat at bedside under the heading of Accidents- Fall Risk and next to Assistive Device. The most recent Fall Risk Evaluation for Resident #47 dated 01/22/21 revealed a score of 15. The document revealed that a score of 12 or above indicated a high risk for fall.	F 689	F689 Free of Accident Hazards/Supervision/Devices 1. Corrective Action On 5/13/21, maintenance director placed fall mats on indicated side(s) of resident #47 and resident #9 bed per Unit Manager (UM) and Center Nurse Executive (CNE) request, per MD order and as noted on care plan as intervention for fall risk. Resident #47 bed removed from against wall by CNE on 05/13/21. Order corrected on resident #9 to have fall mat order listed on resident Treatment Administration Record (TAR) in resident electronic chart on 05/13/21. 2. Others having the potential to be affected. All residents who are at risk for falls as determined by fall risk assessment, have the potential to be affected. All paper Kardex□s removed from resident□s room. Immediate education provided to	

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	345409	A. BUILDING _____ B. WING _____	C 05/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 25 The quarterly Minimum Data Set (MDS) dated 04/22/21 revealed that Resident #47 was severely impaired in cognitive skills for daily decision making and needed the extensive assistance of two staff members for bed mobility and was dependent on two staff members for dressing, toilet use, hygiene and bathing. Resident #47 had no falls since the prior assessment. The Physician Orders dated 10/06/20 revealed an order for a fall mat at bedside every shift. The order did not say which side of the bed the fall mat should be placed. The Physician Progress Note dated 02/16/21 revealed that Resident #47 was a fall risk with a history of falls and impaired mobility. Resident #47 required close attention and constant and frequent evaluation. A safe environment with preventive measures and support to optimize safety and quality of life needed to be provided. The May 2021 Treatment Administration Record (TAR) revealed that the fall mat at bedside every shift order had been initialed as administered (completed) on all three shifts on 05/10/21, 05/11/21, and 05/12/21. The eINTERACT SBAR Summary for Providers dated 05/09/21 at 10:15 PM and completed by Nurse #4 revealed that Resident #47 had a fall from the bed onto the floor and received a skin tear. Resident #47 was lying on her right side between the bed and the window. Resident #47 was assessed by the nurse and placed back in bed. The physician was notified and requested Resident #47 be monitored.	F 689	Activities Assistant and Minimum Data Set (MDS) Nurse on removal of paper Kardex from facility to electronic resident Kardex by CNE on 5/13/21. Fall mat order audit completed on all current residents for order accuracy and placement on TAR, placement of fall mat at resident□s bedside as ordered, and accuracy of care plan for fall mat intervention as ordered. Audit completed by CNE and/or designee on 06/11/21. 3. What measures will be put in place or what systemic changes? Education provided to all Nursing Assistants (NA) on location of Kardex located on electronic POC documentation to ensure accurate device/ADL assistance/resident preferences are available to NAs for care of residents. Education completed by CNE, ACNE and/or designee by 06/14/21. Education provided to all nursing staff to include RN/LPN/NA and agency nursing staff on NSG215 Falls Management, OPS416 Person-Centered Care Plan, ADL documentation and resident Kardex components by CNE, ACNE and/or designee by 06/14/2021. 4. Monitoring of corrective action The CNE/ACNE and/or designee will audit	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345409	A. BUILDING _____ B. WING _____	C 05/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 26 The Assessment note dated 05/09/21 at 10:29 PM revealed that Resident #47 had red bruises to her right hand and wrist and a small skin tear to the left elbow which also had red bruising. In an observation on 05/10/21 at 3:17 PM the right side of Resident #47's bed was against the wall and there were no fall mats on either side of the bed. In an observation on 05/11/21 at 9:18 AM the right side of Resident #47's bed was against the wall and there were no fall mats on either side of the bed. In an observation on 05/11/21 at 1:40 PM the right side of Resident #47's bed was against the wall and there were no fall mats on either side of the bed. In an observation on 05/11/21 at 5:41 PM the right side of Resident #47's bed was against the wall and there were no fall mats on either side of the bed. In an observation and interview on 05/12/21 at 10:23 AM the right side of Resident #47's bed was against the wall and there were no fall mats on either side of the bed. The Hospice Aide stated that she did not recall seeing fall mats on the floor beside Resident #47's bed before. She indicated that Resident #47 had bolsters on her bed but that she was still able to move enough to fall out of the bed. She indicated that she was not in the facility when Resident #47 fell on 05/09/21 but she did know that there were no fall mats when she worked with the resident on 05/10/21 during the day.	F 689	all new active orders daily for accuracy of Fall mat order and placement with Kardex and care plan review, (Monday to Friday to include Saturday/Sunday) weekly x2 weeks, starting 6/14/2021, then monthly x2 months. Results of these audits will be brought before the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and performance Improvement Committee can modify this plan to ensure the facility remains in compliance. Center Nurse Executive and MDS Nurse are responsible for implementation of the plan.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345409	A. BUILDING _____ B. WING _____	C 05/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 27	F 689		

In an interview on 05/12/21 at 2:17 PM Nursing Assistant (NA) #2 stated that the information on how to care for a resident and the equipment they needed was listed on the Kardex on the resident's closet. She indicated that she had not been working when Resident #47 fell out of bed on 05/09/21 but indicated that she had worked the previous shift. NA #2 stated she could not remember if there were fall mats next to Resident #47's bed during her shift.

In a telephone interview on 05/13/21 at 5:17 AM Nurse #4 stated she had been called to Resident #47's room by the NA. She indicated that Resident #47 was lying on the floor on her right side positioned between the bed and the window. She indicated that the bed was not positioned against the wall on the right side of the bed. Nurse #4 indicated that there was a fall mat on the left side of the bed but not on the side of the bed which was where the resident fell.

In an interview on 05/13/21 at 8:11 AM Nurse #1 indicated the NAs knew what equipment each resident needed for their care by receiving report from the NA going off-shift and from the Kardex.

In an interview on 05/13/21 at 8:21 AM NA #3 stated she would know by looking at the Kardex on the closet door, how to care for the resident and what equipment they needed for safety.

In an interview on 05/13/21 at 8:38 AM the MDS Nurse stated the Activities Director was responsible for updating the resident's Kardex but that anyone could add things to it or take them off. She indicated that the Kardex should be updated during care meetings and that she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345409	A. BUILDING _____ B. WING _____	C 05/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEMBROKE CENTER	310 E WARDELL DRIVE PEMBROKE, NC 28372

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F 689	Continued From page 28	F 689		

reviewed the chart and the Kardex. The MDS Nurse indicated that the NAs should use the Kardex on the resident's closet door to get the most current information on how to care for the residents and what equipment they needed.

In an observation and interview on 05/13/21 at 10:29 AM Resident #47 was seen sitting outside the room door in the hallway. The Maintenance Director was in Resident #47's room and a fall mat was seen leaning against the dresser. Resident #47's bed had been positioned away from the wall on the right side and the Maintenance Director indicated that the beds were not supposed to be positioned next to the walls because they caused damage to the walls. The Maintenance Director placed the fall mat on the floor on the left side of Resident #47's bed. When asked why he was placing the fall mat he responded that the Unit Manager (UM) had asked him to put the fall mat in Resident #47's room. He stated that there had not been fall mats in Resident #47's room prior to that day and he knew that because he would have been the one who provided them. When asked about the positioning of the one fall mat he indicated he would need to speak with the UM to see if it needed to be placed on the other side of the bed or if two mats were needed.

In an interview on 05/13/21 at 12:32 PM the UM stated that she requested the Maintenance Director to place the fall mat in Resident #47's room because she did not see one in the room and it was listed on the Treatment Administration Record (TAR). She indicated that nurses should not put their name on something that they did not do. She stated the nurse needed to visualize that the item they were signing for was in use. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345409	A. BUILDING _____ B. WING _____	C 05/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 29	F 689		

UM stated it was a problem if the nurses were signing on the TAR for items that were not in place. She indicated that the interventions they were signing for were important and that they should be checking for their placement before signing them off.

The electronic Visual/Bedside Kardex Report dated as of 05/14/21 did not list fall mats under any category on the report.

In a telephone interview on 05/15/21 at 11:14 AM the Activities Director confirmed that she was responsible for updating each resident's Kardex. She indicated that care meetings were held weekly and that she used a pencil to mark out or make changes to the Kardex. She indicated that the date on the Kardex did not mean anything because it was a working copy and was always being updated. The Activities Director stated the NAs should use the Kardex in the room to provide care for each resident.

In a telephone interview on 05/16/21 at 2:31 PM Nurse #6, who signed that fall mats were in place for Resident #47 on the 7:00 AM-3:00 PM shift on 05/10/21, stated that she signed off tasks at the end of her shift as per how she remembered it. She stated that she should not sign anything off on the TAR without first making sure it was in place.

In a telephone interview on 05/16/21 at 2:54 PM Nurse #9, who signed that fall mats were in place for Resident #47 on the 3:00 PM-11:00 PM and the 11:00 PM-7:AM shifts on both 05/10/21 and 05/12/21, stated that items that were to be checked off every shift "popped up" on the computer at the beginning of the shift. She

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345409	A. BUILDING _____ B. WING _____	C 05/21/2021

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PEMBROKE CENTER	310 E WARDELL DRIVE PEMBROKE, NC 28372

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F 689	Continued From page 30	F 689		

indicated that gave the nurse the whole shift to check to see if the item was in place. She stated that she thought the fall mats had been in place but that she could have signed off that they were in error.

In a telephone interview on 5/16/21 at 3:07 PM Nurse #3, who signed that fall mats were in place for Resident #47 on the 7:00 AM-3:00 PM shift on 05/12/21, stated that she had been assisting another nurse on that shift and the nurse left without signing off the fall mats. She indicated she just signed the item off so the task would change from red and that she did not go down and check to see if the fall mats were in place.

In a telephone interview on 05/17/21 at 11:17 AM NA #7 stated she knew how to take care of a resident, and what equipment they needed, by what was listed on the Kardex in the closet.

In a telephone interview on 05/17/21 at 1:32 PM the DON stated it was her expectation that fall mats should be listed on the Kardex and that the nurses and the NAs should be following the Kardex in the computer and not the Kardex on the resident's closet. She indicated that the NAs began doing electronic charting in April 2021 and the Kardex in the computer was the information that they should use. The DON stated that it was her expectation that nurses not sign off as completed, tasks that they did not do. She indicated the nurse should either inform the oncoming nurse in report or notify her if something still needed to be done. She indicated that if a nurse signed off that fall mats were in place, they should have checked to make sure they were in place and if not, they should place them before signing their name on the TAR.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345409	A. BUILDING _____ B. WING _____	C 05/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEMBROKE CENTER	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
F 689	Continued From page 31	F 689		

2. Resident #9 was admitted to the facility on 11/28/14 and had diagnoses of epilepsy, hemiplegia, and cerebrovascular disease. Resident #9 had a history of falls.

The Care Plan initiated 12/08/14 revealed that Resident #9 was at risk for falls. An intervention of "fall mat at bedside for safety measures (check placement) every shift" was initiated on 04/20/21.

The quarterly Minimum Data Set (MDS) dated 03/03/21 revealed that Resident #9 had short-and-long term memory problems and was severely impaired in cognitive skills for daily decision making. Resident #9 was dependent on 2 staff members for bed mobility, dressing, toilet use and hygiene. Resident #9 had no falls since the prior MDS assessment.

The Physician Orders dated 12/05/20 revealed an order was input electronically into the computer for "Fall mat at the bedside for safety measures. (Check placement). every shift."

The December 2020, January 2021, February 2021, March 2021, April 2021 and May 2021 Medication Administration (MAR) and Treatment Administration Record (TAR) revealed no documentation of the fall mat until 05/13/21 when the order appeared on the TAR for sign-off.

The printed Kardex Report dated 04/08/20 which was hanging on Resident #9's closet door and had been updated by hand did not list fall mat as an intervention for Resident #9.

In an observation on 05/10/21 at 5:38 PM there were no fall mats on either side of Resident #9's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345409	A. BUILDING _____ B. WING _____	C 05/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 689	Continued From page 32	F 689		

bed.

In an observation on 05/11/21 at 9:12 AM there were no fall mats on either side of Resident #9's bed.

In an observation on 05/11/21 at 4:06 PM there were no fall mats on either side of Resident #9's bed.

In an observation on 05/12/21 at 8:11 AM there were no fall mats on either side of Resident #9's bed.

In an interview on 05/12/21 at 8:20 AM Nurse #1 stated that when an order was entered into the computer electronically it was automatically sent to either the MAR or the TAR when the order was completed.

In a follow-up interview on 05/13/21 at 8:11 AM Nurse #1 reviewed the computer MAR and TAR for Resident #9. He confirmed that the order for the fall mat did not "pop-up" as a task to be completed on the computer screen for Resident #9. Nurse #1 indicated the Nursing Assistants (NAs) knew what equipment each resident needed for their care by receiving report from the NA going off-shift and from the Kardex.

In an observation and interview on 05/13/21 at 8:21 AM there were fall mats on both sides of Resident #9's bed. NA #3, who was working in the room, stated she would know by looking at the Kardex on the closet door how to care for the resident and what equipment they needed for safety. NA #3 confirmed that fall mat was not listed on the Kardex hanging on the closet door.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345409	A. BUILDING _____ B. WING _____	C 05/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 33	F 689		

In an interview on 05/13/21 at 8:38 AM the MDS Nurse stated that she had corrected the fall mat order for Resident #9 which had been placed under the ancillary heading so that the order now appeared on the TAR for sign-off by the nurses every shift. The MDS Nurse stated the Activities Director was responsible for updating the resident's Kardex but that anyone could add things to it or take them off. She indicated that the Kardex should be updated during care meetings and that she reviewed the chart and the Kardex. The MDS Nurse indicated that the NAs should use the Kardex on the resident's closet door to get the most current information on how to care for the residents and what equipment they needed.

The electronic Visual/Bedside Kardex Report dated as of 05/14/21 for Resident #9 did not list fall mat under any of the headings on the report.

In an interview on 05/15/21 at 10:56 AM the Maintenance Director stated that the Director of Nursing (DON) requested that he place fall mats on the floor next to Resident #9's bed. He indicated that this was the first time he was made aware that the resident needed fall mats. He indicated that he usually received a work order and then he would place the mats. The Maintenance Director stated that he had not received a work order for placement of fall mats for Resident #9 until he was asked to place them that day by the DON.

In a telephone interview on 05/15/21 at 11:14 AM the Activities Director confirmed that she was responsible for updating each resident's Kardex. She indicated that care meetings were held weekly and that she used a pencil to mark out or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345409	A. BUILDING _____ B. WING _____	C 05/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEMBROKE CENTER	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
F 689	Continued From page 34 make changes to the Kardex. She indicated that the date on the Kardex did not mean anything because it was a working copy and was always being updated. The Activities Director stated the NAs should use the Kardex in the room to provide care for each resident. In a telephone interview on 05/17/21 at 11:17 AM NA #7 stated she knew how to take care of a resident, and what equipment they needed, by what was listed on the Kardex in the closet. In a telephone interview on 05/17/21 at 1:32 PM the DON stated it was her expectation that orders be entered into the computer correctly. She indicated that if they were not entered correctly, they may not show up on the Medication Administration Record (MAR) or TAR for the nurses to complete. She stated that fall mats should be listed on the Kardex and that the nurses and the NAs should be following the electronic Kardex in the computer and not the Kardex on the resident's closet. She indicated that the NAs began doing electronic charting in April 2021 and the Kardex in the computer was the information that they should use.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary	F 690		6/16/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345409	A. BUILDING _____ B. WING _____	C 05/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 690	Continued From page 35 incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, staff, and physician interviews the facility failed to follow up on a urine culture which caused a delay in treatment for 1 of 1 resident (Resident #64) reviewed for Urinary Tract Infections (UTI). Findings included: Resident #64 was admitted to the facility on 10/31/11. The diagnoses included in part, urinary tract infection, sepsis, acute renal failure, leukemia, and diabetes.	F 690	F690 Bowel/Bladder Incontinence, Catheter, UTI 1. Corrective Action. Resident #64 completed antibiotic on 05/09/21 for treatment of UTI. No adverse reactions noted during monitoring per facility protocol. No new concerns noted s/p completion of antibiotic therapy.	

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F 690	Continued From page 36 A progress note dated 04/20/21 at 1:57 PM revealed Resident (#64) was seen by the physician for an acute visit with new orders given for a urinalysis (UA) with culture and sensitivity (C&S) due to complaints of dysuria (painful or difficult urination). A progress note dated 04/21/21 at 5:30 AM revealed an in and out catheterization was performed for urine specimen collection. The lab analysis report for Resident #64's urine sample revealed the specimen was received by the laboratory on 04/21/21 and the final report was verified by the lab and sent to the facility on 04/24/21. The urine culture results revealed there were greater than 100,000 CFU/ml (Colony Forming Units per milliliters) of klebsiella pneumoniae indicating a positive UTI. The organism was shown to be sensitive to Amoxicillin Clavulanate (Augmentin) among other antibiotics. No physician orders were written from 04/21/21 through 04/27/21 to treat the residents (#64) UTI. A phone order was received on 04/28/21 to start Augmentin tablets 875-125 milligrams with instructions to give one tablet by mouth two times a day for UTI for 10 days. The Medication Administration Record (MAR) dated April 2021 revealed the first dose of Augmentin was administered to Resident #64 at 8:00 AM on 04/30/21. A care plan revised 04/28/21 revealed resident (#64) had an actual urinary tract infection with interventions to include, obtain labs and cultures	F 690	2. Others having the potential to be affected. All residents who with ordered UA/C&S labs have the potential to be affected. Audit completed of last 30 days for UA C&S labs by Center Nurse Executive (CNE), Assistant Center Nurse Executive (ACNE) and/or designee by 06/16/21. 3. What measures will be put in place or what systemic changes? Education provided to all licensed nursing staff on facility pharmacy policy, Medication shortages/unavailable medications and NSG115 Physician/Advanced Practice Provider (APP) Notification. Education completed by CNE, ACNE and/or designee by 06/16/21. 4. Monitoring of corrective action The CNE, ACNE and/or designee will audit all new active orders daily for UA C&S lab orders to include follow up, physician notification and treatment initiation,(Monday to Friday to include Saturday/Sunday) weekly x2 weeks, starting 6/14/2021, then monthly x2 months. Results of these audits will be brought before the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality	

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F 690	Continued From page 37 as ordered, report results to physician, and administer antibiotic medications as ordered. The Minimum Data Set (MDS) quarterly assessment dated 04/29/21 revealed Resident #64 was cognitively intact. She was incontinent and required total dependent care with activities of daily living. An observation of incontinent care was conducted on 05/12/21 at 10:45 AM. Resident #64 reported she received antibiotics a few weeks ago for treatment of a UTI and had no further complaints of pain or burning. An interview was conducted on 05/12/21 at 11:10 AM with Nurse Aide # 2. She stated Resident #64 had not voiced any concerns to her regarding signs or symptoms of a UTI. An interview was conducted on 05/13/21 at 1:45 PM with Nurse #2. She stated Resident #64 completed Augmentin a few weeks ago and had no further complaints of burning or pain. A phone interview was conducted on 05/17/21 at 2:00 PM with the Director of Nursing (DON). She reported Resident #64's urinalysis resulted on 04/21/21, and it takes the lab approximately 5-6 days to send a final report for the C&S. During the clinical morning meeting on 04/28/21, as a follow up and for Infection Control surveillance she requested the C&S, it was then noted that the report had not been received by any of the staff nurses or across the fax machine where they were then filed for nurses to receive. She reported the lab was called on 04/28/21 to request a copy of the final report. The lab was sent over, and the unit manager then called the	F 690	Assurance and performance Improvement Committee can modify this plan to ensure the facility remains in compliance. Center Nurse Executive and Nurse Practice Educator will be responsible for implementation of the plan.	

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F 690	Continued From page 38 physician and received the order to begin the antibiotic. A phone interview was conducted on 05/19/21 at 9:43 AM with the facility physician. He stated he did not recall if he was notified of a delay in obtaining the lab results for the UA specimen for Resident #64. He stated he expected the facility to obtain the UA as ordered and then they should have received a preliminary report in a day or so then within a few days would get the final report. He indicated he did not have access to the resident's medical record during the call but stated he didn't think the delay in treatment caused any harm to the resident. A follow up phone interview was conducted on 05/19/21 at 10:45 AM with the DON. She stated the lab picks up the urine specimen after collection, and the results were faxed to the facility. She stated staff should have followed up with the lab sooner. She reported the medication was not available in the facility on 04/28/21 and therefore had to wait for it to be sent from the Pharmacy which was why the first dose was not administered to Resident #64 until 04/30/21.	F 690		
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the	F 727		6/16/21

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F 727	Continued From page 39 director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to prevent the Director of Nursing (DON) from serving as a charge nurse and having a resident care assignment including working on the medication cart with a facility census of greater than 60 residents. Findings included: An observation was conducted on 05/10/21 at 4:00 PM of the 300 hallway (quarantine unit). The DON was observed working on the medication cart. An interview was conducted on 05/10/21 at 4:05 PM with the DON. She stated the evening shift nurse overslept and another nurse would be coming in at 7:00 PM and she had to pick up the assignment at 3:00 PM until the nurse came in at 7:00 PM that evening. The daily staff posting on 05/10/21 revealed a facility census of 73 residents. The daily staffing sheet on 05/10/21 revealed 3 nurses were scheduled for the 3:00 PM- 11:00 PM shift and 1 of the 3 nurses called out for her shift. In an interview with the facility Administrator on 05/10/21 at 5:00 PM he stated he was not aware of a regulation that prevented a DON from	F 727	F727 RN 8Hrs/7 days/Wk, Full Time DON 1. Corrective Action. Center Nurse Executive (CNE) has not worked a resident assignment since 05/17/2021. 2. Others having the potential to be affected. All residents would be affected if the Center Nurse Executive is not able to dedicate 40 hours a week to the role. 3. What measures will be put in place or what systemic changes? Education provided to Center Executive Director (CED) and Center Nurse Executive (CNE) on facility policy NSG112 Nursing Services, facility policy OPS138 Staffing/Center Plan and facility policy OPS130 Posting Staffing. Education completed by Senior Administrator, Center Nurse Consultant and/or designee by 06/16/21. 4. Monitoring of corrective action. Regional Human Resource manager	

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F 727	Continued From page 40 working as a charge nurse if the average daily facility census was greater than 60. He explained that in every building he had worked in as an administrator, the DON was utilized as a charge nurse, if needed. After reviewing the State Operations Manual he acknowledged Federal Regulation 483.35. In an interview with the DON on 05/11/21 at 10:15 AM she stated she was aware of the regulation that prohibited a DON from serving as a charge nurse when the average daily census was greater than 60. She explained when she brought up the regulation other staff accused her of "just not wanting to work the assignment" so she took the assignments and worked as a charge nurse when asked. A review of the daily staffing sheets from 05/11/21 through 05/16/21 revealed the DON was on the staff schedule dated 05/14/21 for the 3:00 PM - 11:00 PM shift and had a resident assignment. The facility census on 05/14/21 was 68 residents. A phone interview was conducted on 05/17/21 at 2:00 PM with the DON. She stated due to staff call outs she had to take a resident assignment on 05/14/21 for the 3:00 PM - 11:00 PM shift. She stated she also had a resident assignment for 8 hours on 05/15/21 and 05/16/21 with a facility census of 68 residents, due to staff not showing up for work. She stated she had to take a resident assignment at least 1-2 times a week over the last several weeks. She reported the nurses rotate call and are utilized in the event of someone calling out for their shift. She confirmed along with the DON responsibilities she was also the Infection Control Nurse. She reported the facility was making every effort to hire more staff.	F 727	and/or designee will audit staffing weekly to ensure adequate coverage. Results of these audits will be brought before the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and performance Improvement Committee can modify this plan to ensure the facility remains in compliance. CED and CNE will be responsible for implementation of the plan.	

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F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.	F 756		6/16/21

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F 756	Continued From page 42 This REQUIREMENT is not met as evidenced by: Based on record review and Consultant Pharmacist and staff interviews the Consultant Pharmacist failed to report blood sugar (BS) monitoring irregularities for 1 of 6 residents (Resident #171) whose medications were reviewed. Findings included: Resident #171 was readmitted to the facility from the hospital on 02/22/21 and had diagnoses of diabetes mellitus and a Urinary Tract Infection (UTI). Physician orders dated 02/22/21 revealed that Resident #171 was ordered Novolog insulin to be injected on a sliding scale subcutaneously as needed. The parameters for administration of the insulin were: if BS was between 201-250 administer 2 units of insulin, if BS was between 251-300 administer 4 units of insulin, if BS was between 301-350 administer 6 units of insulin, if BS was between 351-400 administer 8 units of insulin, and if BS was greater than 400 administer 10 units of insulin and call the physician. The order did not direct how often to monitor Resident #171's BS. The Medication Administration Record (MAR) for 02/22/21-03/23/21 revealed no documentation that BS monitoring had been completed or that any sliding scale insulin (SSI) had been administered. Physician orders dated 02/23/21 revealed that Resident #171's insulin was changed from Novolog to Humalog insulin with the same parameters. The order did not list how often to monitor Resident #171's BS.	F 756	F756 Drug Regimen Review, Report Irregular 1. Corrective Action. Resident #171 no longer resides at facility. 2. Others having the potential to be affected. All residents with Sliding Scale Insulin (SSI) orders have the potential to be affected. Complete audit of SSI orders x30 days completed by Center Nurse Executive (CNE), Assistant Center Nurse executive (ACNE) and/or designee for completeness and accuracy of MD order by 6/16/2021. 3. What measures will be put in place or what systemic changes? Education provided to all licensed nursing staff on facility policy NSG117 Transcription of orders and Diabetic Protocol. Education provided by CNE, ACNE and/or designee by 06/16/21. 4. Monitoring of corrective action. The CNE, ACNE and/or designee will audit all new active orders daily for SSI orders to ensure accuracy of order and accurate monitoring documentation,	

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F 756	Continued From page 43 The Physician's Progress Note dated 02/23/21 revealed Resident #171 was being seen by the physician after readmission to the facility from the hospital for a UTI. The plan was to continue and complete the course of antibiotic therapy. In addition, the plan was to monitor Resident #171's BS and adjust the medication as indicated. The Consulting Pharmacist Medication Regimen Review (MRR) Note dated 02/24/21 and written by Consultant Pharmacist #2 who no longer worked for the company and was not available for interview, revealed there were no irregularities in Resident #171's orders. The note went on to say that "Based upon the information available at the time of the review, and assuming the accuracy and completeness of such information, it is my professional judgement that at such time, the resident's medication regimen contained no new irregularities." The 5-day Minimum Data Set (MDS) dated 03/01/21 revealed that Resident #171 was moderately impaired in cognitive skills for daily decision making. Resident #171 received no injections and no insulin during the seven day look back period. The Consulting Pharmacist Medication Regimen Review (MRR) dated 03/16/21 and written by Consultant Pharmacist #2 who no longer worked for the company and was not available for interview, revealed there were no irregularities in Resident #171's orders. The note went on to say that "Based upon the information available at the time of the review, and assuming the accuracy and completeness of such information, it is my professional judgement that at such time, the	F 756	(Monday to Friday to include Saturday/Sunday) weekly x2 weeks, starting 6/17/2021, then monthly x2 months. Results of these audits will be brought before the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and performance Improvement Committee can modify this plan to ensure the facility remains in compliance. CNE will be responsible for implementation of the plan.	

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F 756	Continued From page 44	F 756		

resident's medication regimen contained no new irregularities."

In a telephone interview on 05/17/21 at 10:15 AM Consultant Pharmacist #1 stated that she took over the position from Consultant Pharmacist #2 in May 2021. She indicated that Consultant Pharmacist #2 should have caught that the BS for SSI was not being checked for Resident #171 when he performed his monthly medication reviews. Pharmacy Consultant #1 stated that the Physician, the facility, and the Consultant Pharmacist should all have realized that Resident #171's BS was not being monitored. She indicated that to know how much SSI to administer the nurse would have to know what the BS reading was, and that the order should have been documented as an irregularity by Consultant Pharmacist #2 so the order could have been clarified with the physician to see how often he wanted the BS to be monitored.

In a telephone interview on 05/17/21 at 1:32 PM the Director of Nursing (DON) indicated that if the order did not include times to monitor the BS, such as before meals, the physician would need to be called and the order clarified. The DON indicated that she felt the monitoring of Resident #171's BS was just left off the order, was not clarified, and was just an error. She stated that she had not received a recommendation from Pharmacist Consultant #2 to monitor Resident #171's BS for his SSI and she would have expected him to report this to her.

In a telephone interview on 05/17/21 at 1:59 PM Resident #171's Physician stated that BS monitoring for SSI should be performed before meals and at bedtime. He indicated that if the

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F 756	Continued From page 45 times for monitoring were not included in the order, that someone should have called him to clarify the order. The Physician indicated that he expected his orders to be followed and if there were any questions he should be notified, and the orders clarified. The Physician indicated that the Consultant Pharmacist or one of the nurses should have realized that Resident #171's BS was not being monitored.	F 756		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced	F 761		6/18/21

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F 761	Continued From page 46	F 761		

by:
Based on observation and staff and Consultant Pharmacist interviews the facility failed to discard two opened and accessed bottles of eye drops per the pharmacy label on the box and failed to store an opened and accessed bottle of liquid nebulizer medication in the refrigerator as directed by the pharmacy label for 1 of 2 medication carts observed. The facility also failed to label and place an opened date on an open and accessed bottle of liquid nebulizer medication in the medication room refrigerator for 1 of 1 medication storage rooms observed. Findings included:

On 05/12/21 beginning at 8:40 AM the 100-hall medication cart was observed for medication storage accompanied by Nurse #1. An opened and accessed bottle of Olopatadine 0.2% ophthalmic drops used for allergies was found in the cart. The opened date on the bottle was 01/27/21 and the pharmacy label read to discard after six weeks. The pharmacy label information was confirmed by Nurse #1 who indicated that the medication should have been discarded in approximately mid-March 2021 after being open for six weeks. Nurse #1 indicated that the medication would be discarded and reordered.

Continuing the medication storage observation of the 100-hall medication cart with Nurse #1 an open and accessed bottle of Latanoprost .005% ophthalmic drops used for glaucoma was found. The bottle had no open date and the pharmacy label instructed that the medication be discarded six weeks after opening. The medication did have a dispensed date of 08/17/20. Nurse #1 stated that the pharmacy label instructions should have been followed and since there was no open

F761 Label/Store Drugs and Biological

1. Corrective Action.

Opened bottle of Olopatadine 0.2% with an open date of 01/27/21 with directions to discard after 6 weeks, discarded on 05/12/21 and re-ordered.

Latanoprost .005% observed with no open date with pharmacy instructions to discard after 6 weeks, discarded 05/12/21 and re-ordered.

30 mL bottle Acetylcysteine used for nebulizer treatments observed to have no open date and to refrigerate after opening per pharmacy instructions, discarded on 05/12/21 and re-ordered.

Opened 30 mL bottle of Acetylcysteine liquid used for nebulizer treatments, observed without open date or labeling of resident name observed stored in medication room, discarded 05/12/21.

2. Others having the potential to be affected.

All residents with ordered medications have the potential to be affected.

Medication carts and medication storage rooms located on each unit audited by Center Nurse Executive (CNE), Assistant Center Nurse executive (ACNE) and/or designee for compliance of Medication storage per facility and pharmacy

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	345409	A. BUILDING _____ B. WING _____	C 05/21/2021

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F 761	Continued From page 47 date on the bottle, he had no idea how long the medication had been open in the drawer. He indicated that the eye drops would be discarded and reordered. Continuing the medication storage observation of the 100-hall medication cart with Nurse #1 an open and accessed 30 ml (milliliter) bottle of acetylcysteine used for nebulizer treatments was in a labeled bag which also contained an un-accessed 30 ml bottle of the medication. There was no open date on the bottle and the pharmacy label instructed that the medication needed to be refrigerated after opening. Nurse #1 confirmed that the bottle of acetylcysteine had been accessed as the level of the liquid in the bottles was different. He indicated that he would dispose of the bottle of unrefrigerated medication. In an observation of the 100-200 medication storage room refrigerator with Nurse #1 on 05/12/21 at 2:35 PM an undated, opened, and accessed 30 ml bottle of acetylcysteine liquid for nebulizer treatments was sitting on the shelf. Tape had been placed over the access point on top and it contained approximately ¼ of its volume. There was no resident name to identify who the medication was intended for on the bottle and there was no pharmacy label. When the bottle was found, Nurse #1 stated that it was not the same bottle that had been on the medication cart. He indicated that he had disposed of that bottle of medication. In an interview on 05/13/21 at 12:26 PM Nurse #1 stated that it was the responsibility of each nurse who worked on the medication cart to check the cart for medication storage issues. He indicated that prior to administering a medication,	F 761	guidelines by 06/18/21. 3. What measures will be put in place or what systemic changes? Education provided to all licensed nursing staff on facility□s pharmacy services and procedures manual: Storage and Expiration dating of medications, biologicals, syringes and needles. Education provided by CNE, ACNE and/or designee by 06/18/21. 4. Monitoring of corrective action. The CNE, ACNE and/or designee will audit all medication carts and medication storage rooms on both units weekly x4 weeks, starting 6/21/2021, then bi-weekly x2 weeks, then monthly x2 months. Results of these audits will be brought before the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and performance Improvement Committee can modify this plan to ensure the facility remains in compliance. CNE will be responsible for implementation of the plan.	

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F 761	Continued From page 48	F 761		

expiration dates should be checked, and pharmacy label instructions should always be followed.

In a telephone interview on 05/14/21 at 4:39 PM Consultant Pharmacist #1 stated that if the pharmacy label for the Olopatadine 0.2% directed to discard the eye drops six weeks after opening then it would be considered expired at that time and should not be used. She indicated that the pharmacy instructions should always be followed and that after six weeks of being open the sterility and stability of the eye drops could not be guaranteed. She indicated that for the Latanoprost .005% eye drops if there was no opened date she would have to go by the dispensed date and add one day. She indicated that she would then consider that to be the opened date (08/18/20) and the eye drops would be considered expired after six weeks and should not be used. She stated that after being opened for six weeks the sterility and stability of the eye drops could not be guaranteed. Consultant Pharmacist #1 stated again the instructions on the pharmacy label should always be followed. She stated that if the pharmacy label on the acetylcysteine directed to refrigerate after opening then that is what should have been done. Pharmacist Consultant #1 stated that the acetylcysteine once opened and refrigerated was only good for 96 hours and should not be used after that time. She indicated that she was unable to say what harm could be caused by using acetylcysteine that was not stored in the refrigerator after opening or the harm that could be caused by using acetylcysteine past the 96-hour window. She indicated she would do some research and reach out with more information.

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F 761	Continued From page 49 In a follow-up telephone interview on 05/17/21 at 10:15 AM Consultant Pharmacist #1 stated she had been unable to find out any harm information for acetylcysteine other than the effectiveness and sterility could not be guaranteed unless the pharmacy instructions were followed. In a telephone interview on 05/17/21 at 1:32 PM the Director of Nursing (DON) stated that she expected the nurses to check the medication carts every shift for outdated and mis-stored medications. She indicated that she expected the nurses to read the pharmacy labels for special instructions and to date medications when they were opened. She indicated that if a medication label directed a medication be stored in the refrigerator after opening then it should be stored in the refrigerator. She stated that unlabeled medications should be discarded and that expired medications should be taken off the medication cart. The DON stated that it was important to do these things because if they weren't done the medication might not be as effective or may even cause harm to the resident depending on the medication.	F 761		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control	F 880		6/18/21

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F 880	Continued From page 50	F 880		

program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct

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F 880	Continued From page 51 contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interviews the facility failed to implement a policy to follow guidelines established by the Center for Disease Control and Prevention (CDC) dated 11/20/20. This policy indicated personal protective equipment (PPE) to include a gown, gloves, face mask, and eyewear was to be worn when caring for newly admitted residents under quarantine when their COVID status was unknown. No eye protection or gown PPE was worn by 1 of 1 Nursing Assistants (NA #5) observed on the facility's Admission Observation Unit (AOU). This occurred when NA #5 failed to wear eye protection and a gown when entering resident room numbers #308, #312, and #314 (Example #1), and failed to follow the facility's infection control policy by not bagging soiled linen and a soiled brief, leaving them on the floor of the resident's room (Example #2). These breeches in infection control practices occurred during a global pandemic.	F 880	F880 Infection Prevention and Control 1. Corrective Action. Immediate education provided to NA #5 regarding proper PPE for Contact plus airborne precautions for residents residing in room specific AOU on 05/10/21 by Center Nurse executive (CNE). Immediate education provided to NA #5 on facility Infection Policies and Procedures policy IC204 Linen Handling by CNE on 05/13/21. 2. Others having the potential to be affected. All residents have the potential to be affected.	

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F 880	Continued From page 52 Findings included: A facility document titled, "PPE: Guidance for Mask Usage and Respiratory Protection" dated 05/12/21 indicated in part: Persons entering the room of a patient suspected or diagnosed with COVID-19, a patient/resident under observation status on or off of the Admission Observation Unit (AOU) or working on a unit with a COVID outbreak are to wear a respirator with a face shield." A bright orange facility AOU Entrance Sign titled, "AOU Entrance" indicated in part: You MUST have your N95 and goggles/face shield donned upon entrance to the unit. A red and black facility new admission/quarantine resident door sign titled, "Patient-Specific Contact Plus Airborne Precautions for special respiratory circumstances" indicated in part: Wear an N95/approved KN95 Respirator, Gown, Face Shield and Gloves upon entering this room. A review of a document updated 11/20/20 and published by the CDC titled: "Preparing for COVID-19 in the Nursing Home" indicated in part under section headed Evaluate and Manage Residents with symptoms of COVID-19, resident known or suspected of COVID-19 should be cared for by Health Care Personnel (HCP's) using all recommended PPE which includes use of a N-95 or higher level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or face shield that covered the front and sides of the face) gloves and gown. The document defines HCP to include but not limited to, nurses, nursing assistants, physicians, technicians, therapists, phlebotomist, pharmacist,	F 880	3. What measures will be put in place or what systemic changes? Education provided to all staff facility policy IC405 COVID-19 and Personal protective equipment (PPE) Use, reuse, and extended use of PPE for all Healthcare staff and providers. Education provided by CNE, ACNE and/or designee by 06/18/21. 4. Monitoring of corrective action. The CNE, ACNE and/or designee will complete a PPE audit of 10 random staff members weekly x4 weeks, starting 6/21/2021, then bi-weekly x2 weeks, then monthly x2 months. Results of these audits will be brought before the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and performance Improvement Committee can modify this plan to ensure the facility remains in compliance. CNE will be responsible for implementation of the plan.	

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F 880	Continued From page 53	F 880		

students and trainees, contractual staff not employed by the facility, and person not directly involved in patient care, but who could be exposed to infectious agents that can be transmitted in the healthcare setting i.e., clerical, dietary, environmental services, laundry, security, engineering, and facility management, administrative, billing, and volunteer personnel.

A review of a document updated 11/15/20 titled: "IC307 Standard Precautions" indicated in part under section #10. Handle, transport, and process used linen soiled with blood and/or body fluid in a manner that prevents skin and mucous membrane exposures, contamination of clothing, and avoids transfer of microorganisms to other individuals and the environment.

Example #1: An observation an interview on 05/10/21 at 5:18 PM Nurse Aide (NA) #5 entered residents' rooms #308, #312, and #314 on the quarantine (AOU) hall without eye protection or gown on. NA #5 was observed as she passed out residents' meal trays and exited their rooms. NA #5 did not have a gown or eye protection on and wore the same gloves in all three rooms. When asked why she was not wearing a gown, eye protection, and wore the same gloves in all 3 rooms. NA #5 responded that she should have donned full Personal Protection Equipment (PPE) before she entered the three quarantined residents' rooms but was in a hurry and forgot. Signage for patient-specific contact plus airborne precautions were observed on all 3 of the 3 quarantine residents' room doors. The patient-specific contact plus airborne precautions signage indicated gown, gloves eye protection/face shield, and N95 mask to be donned prior to entering residents' rooms.

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F 880	Continued From page 54	F 880		

An interview on 05/10/21 at 5:25 PM with the Director of Nursing (DON) revealed it was her expectation that NA #5 should have followed the facility's infection control policy and donned full PPE when she entered the three resident quarantine rooms on the AOU and did not.

A follow-up interview on 05/12/21 at 10:03 AM with the DON revealed all facility staff and visiting personnel must wear full PPE, when they enter quarantine rooms on the AOU.

An interview on 05/12/21 at 12:00 PM with the Administrator confirmed that facility staff must wear full PPE when they enter a quarantine room on the AOU unit.

Example #2: An observation on 05/13/21 at 9:40 AM Nursing assistant (NA) #5 was in quarantine resident room # 314 on the AOU with unbagged soiled linen and a soiled adult brief laying on the floor at the foot of room # 314's bed, with no gown on.

A follow-up interview was conducted on 05/13/21 at 9:45 AM with NA #5. She stated she was in room #314 doing the resident's bed bath, incontinent care, and bed linen change. She said she was in a hurry and deposited room #314's soiled lined and incontinent brief with the fecal contents exposed on the floor without being bagged first. NA #5 reported she should have bagged the soiled linen and incontinent brief prior to placing them on the floor; but, she did not. NA #5 reported she was aware that placing the soiled linen and soiled incontinent brief on the floor was an infection control issue, but she was trying to get the resident's care completed quickly.

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F 880	Continued From page 55 During an interview on 05/14/21 at 4:30 PM with the facility's Director of Nursing (DON) she said it was her expectation that all soiled linen and briefs be bagged by nursing staff, and not just placed unbagged on resident floors. During an interview on 05/14/21 at 4:50 PM with the facility's Administrator he stated it was his expectation that all staff fully follow all the facility's infection control policies, and for all staff to wear full PPE when they entered an AOU quarantined resident room. He also stated that all soiled linen and briefs must be first bagged by facility staff prior to placing them on the resident's floor.	F 880		