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 06/29/2023

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 000	INITIAL COMMENTS A complaint investigation was conducted from 06/27/23 through 06/29/23. The following intakes were investigated: NC00199590, NC00200787, NC00200494, and NC00202616. 1 of the 8 allegations resulted in deficiency.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §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 record review and staff interview, the facility failed to follow a physician order for fall mats at both sides of the bed for a resident with a history of falls for 1 of 1 resident (Resident #3) sampled for supervision to prevent accidents. The findings included: Resident #3 was admitted to the facility on 11/14/22. His diagnoses included: dementia and unsteady gait. A review of Resident #3's physician order dated 11/14/22 revealed to place a fall mat to both sides of bed and to check for placement every shift. This order was placed on the Treatment Administration Record (TAR). Resident #3's active care plan, dated 06/16/23,	F 689	1. Resident # 3 was discharged from the center on 6/21/23. 2. All residents who are a fall risk have the potential to be affected. An audit was completed for all residents with fall mat orders to ensure that their fall mats were at bedside per order. All residents with a fall in the last 30 days were reviewed to determine that appropriate interventions were put into place for their fall. Care plans reviewed to ensure that all interventions on the care plan are in place accordingly. 3. Education provided to all licensed nurses by the Nurse Practice Educator or designee on the falls management policy – including implementing interventions as	7/6/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 07/13/2023

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

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F 689	Continued From page 1 included a focus area for risk for falls due to cognitive loss, lack of safety awareness and impaired mobility. The interventions included fall mats to both sides of the bed that was initiated on 11/14/22. A review of Resident #3's quarterly Minimum Data Set (MDS) assessment dated 06/21/23 indicated Resident #3 had moderately impaired cognition and required limited to extensive assistance with Activities of Daily Living (ADLs). A wheelchair was used for mobility. Resident #3 was coded with 8 falls since the last MDS assessment dated 11/11/22. Observations were made on 06/27/23 at 10:45 AM, 06/28/23 at 7:45 AM, and 06/29/23 at 8:05 AM of Resident #3 in bed without a fall mat to both sides of bed. An interview was conducted with Nursing Aide #2 on 06/29/23 at 10:02 AM. She said she was assigned to Resident #3 that day. She said she was familiar with Resident #3 and had worked with him before. She said he would try to get up by himself and that it was easy to re-direct him to keep him from falling. She said she had seen fall mats by his bed before but could not remember when they were there or what happened to them. She said the nurses would know what happened to them, because the nurses were responsible for checking on them. She said she did not see them, nor was it her responsibility to make sure they were by the resident's bed. A phone interview was conducted with Nurse #6 on 06/29/23 at 10:16 AM. She stated she was familiar with Resident #3 and that he had a fall mat on the floor next to the right side of his bed	F 689	ordered and careplanned, for any fall that occurs to prevent a recurrence. 4. All falls will be reviewed by the Nursing Leadership Team in the Clinical Morning Meeting to determine that appropriate interventions are put into place to prevent a recurrence and that these interventions are care planned. Fall Mat audits will be conducted daily for 21 days, then weekly x 2 weeks, then monthly x 2 months. All results will be presented to the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance.	

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F 689	Continued From page 2 but did not have a fall mat on the left side of his bed. She said she could not remember if his fall mat order was for one or two. She said Resident #3's fall mat placement was to be checked every shift with documentation to be completed on the TAR. She indicated she worked with Resident #3 on 06/26/23, 06/27/23, and 06/28/26 during the 1st shift but was unable to explain why Resident #3 had only one fall mat, which was placed on the floor on the left side of his roommate's bed. An interview was conducted with Nurse #1 on 06/29/23 at 8:38 AM. She stated she was familiar with Resident #3 and that he had an order for his fall mat to be checked for placement every shift. She revealed that Resident #3 had two fall mats in the past. Nurse #1 stated she worked with Resident #3 on 06/29/23 during the 1st shift. She was unable to explain why a fall mat was not next to both sides of Resident #3's bed. An interview was conducted with the Director of Nursing (DON) on 06/29/23 at 8:40 AM. He stated that fall mat monitoring for placement was to be completed and documented on the TAR once on every shift. He stated that his expectation was for physician's ordered 2-fall mats to be in place and that monitoring documentation to be fully completed.	F 689		