

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345409	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/20/2026
NAME OF PROVIDER OR SUPPLIER Pembroke Center			STREET ADDRESS, CITY, STATE, ZIP CODE 310 E Wardell Drive , Pembroke, North Carolina, 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
F0000	INITIAL COMMENTS The survey team entered the facility on 01/12/26 to conduct a complaint investigation survey and exited on 01/14/26. Additional information was obtained on 01/20/26. Therefore, the exit date was changed to 01/20/26. The following intakes were investigated: 2715828, 2694890, 2691249, 267798, 2681795, and 2677633. 2 of the 9 complaint allegations resulted in deficiency.	F0000		01/27/2026
F0760 SS = D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on record reviews, and interviews with staff, Director of Nursing, Pharmacist, Administrator, and the Medical Director, facility failed to verify right patient before administering insulin, which resulted in an insulin injection being administered to a resident with the same last name without an insulin order for 1 of 1 resident reviewed for significant medication errors (Resident #19). The findings included: Resident #19 was admitted to the facility on 01/06/26 with diagnoses of influenza, pneumonia, and did not include diabetes (DM). Resident #19's Admission Minimum Data Set (MDS) dated 01/13/26 revealed Resident #19 was cognitively intact. Resident #19's physician orders for January/2026 listed: Oxygen at 3 liters nasal cannula, albuterol,	F0760	F0760 Resident #19 was discharged home from the facility 1/19/26. 2. All residents have the potential to be affected by the medication error. Residents with BIMs score of 12 or less were assessed by the DON on 1/12/26 to ensure that they did not have any signs of symptoms of having the wrong medication administered. Residents were assessed for signs and symptoms of hypo/hyperglycemia. No concerns were identified. Residents with BIMs score of 13 or greater were interviewed to ensure that they were being administered the correct medication by members of the administrative team on 1/13/26. No concerns were identified. 3. On 01/12/26, the Director of Nursing conducted an audit of Resident Room name plates to the Electronic Medical Record to ensure accuracy. No identified concerns identified On 01/12/26, the Director of Nursing verified each resident's photo in electronic Medical records to include eMAR. No concerns identified.	01/27/2026

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F0760 SS = D	<p>Continued from page 1 digoxin, and metoprolol. The physician orders did not include an order for insulin.</p> <p>Review of Resident #19's Electronic Medication Administration Record (E-MAR) dated January 2026 revealed no order listed for insulin.</p> <p>A nursing note dated 01/12/26 at 7:24 PM for Resident #19 revealed on 01/12/26 at 4:30 PM the resident was given 10 units of Lispro insulin and was not on insulin. Resident #19 was given glucose by doctor's order. Resident's blood glucose on 01/12/26 at 6:28 PM was 149. Patient's blood sugar levels were monitored and remained within normal limits, with patient stable. (Insulin lispro is a fast-acting insulin that starts to work about 15 minutes after injection, peaks in about 1 hour, and keeps working for 2 to 4 hours.) (Normal blood sugar levels for non-diabetic adults range from 70 to 140).</p> <p>A Medical Director order dated 01/12/26 at 5:00 PM for Resident #19 revealed to administer one tube (24 grams) of Insta-glucose gel stat, which was given. (Insta-glucose gel is a fast-acting glucose used to treat very low blood sugar.)</p> <p>An interview was conducted on 01/14/26 at 9:10 AM with Nurse #1. The nurse said on 01/12/26 around 4:30 PM she was working on the medication cart on the 300-hall. She said she administered 10 units of Lispro (insulin) to Resident #19 instead of intended resident with the same last name. She said she immediately reported the medication error to the Unit Manager, who notified the Nurse Practitioner, who ordered glucose gel to be administered, vital signs and assessment done, along with 15-minute blood glucose levels check, which she did. Nurse #1 stated resident's blood sugar remained within normal limits and Resident #19 had no side effects. She said the Medical Director and resident's Responsible Party (RP) were informed of the medication error. Nurse #1 said she gave the insulin in error, was distracted, and should have paid closer attention to giving out medications to residents with the same last name.</p> <p>An interview was conducted on 01/13/26 at 3:48 PM with Unit Manager #2. She said on 01/12/26 around 4:30 PM she was working on the 400 short hall. She said Nurse #1 came to her and said she gave 10 units of insulin to the wrong resident. The Unit Manager said she immediately checked Resident #19's blood sugar which was 100, then reported the incident to the Director of Nursing and the Nurse Practitioner, who ordered glucose gel to be administered, vital signs and assessment</p>	F0760	<p>Continued from page 1 A name alert banner was added in the Electronic Medical Record for residents identified as having the same last name by the Director of Nursing on 01/12/26</p> <p>On 01/12/26, Licensed Nurses and Certified Medication Aides were educated on Nursing policy NSG 306 medications errors by the Director of Nursing, and/or the Nurse Manager. Any nurse who was not educated will be educated prior to their next shift. All newly hired Licensed Nurses and Certified Medication Aides will be educated during their orientation on the medication error policy by the Director of Nursing/designee.</p> <p>Overall responsibility for ensuring completion, compliance, and ongoing education is overseen by the Director of Nursing.</p> <p>The Director of Nursing will review and evaluate the staff schedule for licensed nurse assignments and medication aide assignments to ensure licensed nurses can perform assessment and administer medications that are required by a licensed nurse.</p> <p>Auditing was initiated on 01/12/26 to evaluate compliance with the facility's medication administration policy, including adherence to the 5 rights and resident identification procedures. The Director of Nursing and Nurse Managers are completing random audits of medication administration passes on 2 residents, 5 x per week for 4 weeks, then 3 x week for 4 weeks, then 1 x per week for 4 weeks.</p> <p>The Director of Nursing will assign staff to obtain photographs and upload in the Electronic Medical Record of newly admitted residents after hours and weekends to ensure compliance. The Director of Nursing or Nurse Managers will conduct audits of newly admitted residents 5 x week for 4 weeks, 3 x week for 4 weeks and 1 x week for 4 weeks.</p> <p>4. The results of the quality monitoring will be reported by the Director of Nursing or Nurse Managers to the Quality Assurance Performance Improvement Committee Meeting monthly for 3 months. Quality Monitoring schedules may be modified based on quality monitoring findings. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Nursing, Nursing Supervisors, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse and at least one direct care staff. The facility will audit to ensure compliance of the deficient practice through audits and</p>	

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F0760 SS = D	<p>Continued from page 2 done, along with blood glucose levels checked. Unit manager stated resident's blood sugar remained within normal limits and Resident #19 had no side effects from the insulin.</p> <p>Resident #19's blood sugar levels: 01/12/25 at 5:02 PM – 100, 01/12/25 at 5:18 PM – 114, 01/12/25 at 6:28 PM – 149, 01/12/25 at 9:00 PM – 100, 01/12/25 at 11:00 PM – 115, and 01/13/25 at 1:19 AM – 103.</p> <p>An interview was conducted on 01/13/26 at 3:25 PM with Resident #19. The resident stated on 01/12/26 just before dinner she was given an insulin injection in her right arm by Nurse #1. She stated after the injection, she asked the nurse what she gave her and was told her evening insulin. The resident told the nurse that she was not diabetic and was not on insulin. Resident #19 stated she had no reactions from the insulin, and soon after getting the injection, she was given glucose gel and was monitored by nursing staff.</p> <p>An interview was conducted on 01/14/26 at 9:36 AM with the Director of Nursing (DON). She stated it was her expectation that Nurse #1 followed their policy on medication errors and to have verified the right resident, the right medication, the right dose, and right route; before she administered the 10 units of Lispro (insulin) to Resident #19.</p> <p>An interview was conducted on 01/14/26 at 9:55 AM with the facility's Pharmacist. She confirmed Resident #19 received 10 units of Lispro insulin in error on 01/12/26 around 5:15 PM. The Pharmacist indicated Nurse #1 mistakenly gave the insulin to the wrong resident and noted the resident who was prescribed the insulin and Resident #19 both had the same last name. She said the only possible drug interaction was that of metoprolol, which could mask the effects of hypoglycemia. However, Resident #19 only received one 10-unit low dose of insulin, and was taking metoprolol in the mornings, which most likely wouldn't have this masking effect. The Pharmacist said the resident's blood sugar was closely monitored for about 2 hours after the 10-unit insulin administration, with no drug interactions. The Pharmacist stated a normal adult's blood sugar was 80 to 90, and that Resident #19 blood sugar checks after the one dose insulin administration was never below 100 and remained above the normal adult blood sugar range.</p> <p>An interview was conducted on 01/13/26 at 3:20 PM with the Medical Director. He confirmed on 01/12/26 at approximately 4:30 PM Resident #19 was accidentally administered 10 units of Lispro (insulin) that was</p>	F0760	Continued from page 2 education.	

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F0760 SS = D	<p>Continued from page 3 intended for another resident with the same last name during medication pass. He said the nurse notified her unit manager; resident was assessed with vital signs and blood sugar check, was given glucose per order, and remained stable with blood sugar of 100, with no aftereffects, and no harm.</p> <p>A follow-up Medical Director progress note for Resident #19 dated 01/14/26 at 10:57 AM stated: "[Resident #19] was noted to have received on 01/12/26 insulin Lispro (generic Humalog) 10 units in error. [Resident #19] sustained no adverse effect. Indeed, 10 units is not considered a high dose, and in this case, the likelihood of any adverse effects was nil. Moreover, the actions of the staff member in administering glucose gel, further ensured that any adverse effects were not likely to occur. Therefore, the likelihood for harm in this case was nil."</p> <p>An interview was conducted on 01/14/26 at 9:49 AM with the Administrator. She stated it was her expectation that Nurse #1 followed their policy on medication errors and to have verified the right resident, before she administered the 10 units of insulin to Resident #19, which she did not do.</p>	F0760		