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 11/20/2024

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

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E 000	Initial Comments A recertification survey and complaint investigation was conducted onsite 11/03/24 through 11/08/24 . Additional information was obtained remotely on 11/20/24. Therefore, the exit date was 11/20/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #7PHB11.	E 000		
F 000	INITIAL COMMENTS A recertification survey and complaint investigation was conducted onsite 11/03/24 through 11/08/24 . Additional information was obtained remotely on 11/20/24. Therefore, the exit date was 11/20/24. Event ID# 7PHB11. The following intakes were investigated NC00220323, NC00223461, NC00221967, NC00223408, NC00221891, NC00221923, and NC00220762. 6 of the 10 complaint allegations resulted in deficiency.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-	F 600		12/18/24

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

Electronically Signed | 12/16/2024

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F 600	Continued From page 1 §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, and resident and staff interviews, the facility failed to protect a resident's right to be free from physical abuse. Resident #80 removed some of Resident #67's belongings from her room and when Resident #67 went to retrieve the belongings Resident #80 denied having them. Resident #80 then swung at Resident #67, and in response, Resident #67 punched Resident #80 in the forehead with a closed fist for 1 of 4 residents reviewed for abuse. Resident #80 was not injured. The findings included: Resident #80 was admitted to the facility on 10/23/23 with diagnoses that included vascular dementia with other behavioral disturbance, altered mental status, and generalized anxiety disorder. Review of a quarterly Minimum Data Set (MDS) assessment dated 07/03/24 documented that Resident #80 had severely impaired cognition. During the assessment look back period she had verbal behaviors directed toward others on 1 to 3 days. Wandering occurred daily and she wore a wander/elopement alarm. She was able to stand and walk independently and also used a wheelchair. The care plan for Resident #80 (initiated 03/14/24) documented the following focal area: Resident exhibits or has the potential to demonstrate verbal behaviors related to:	F 600	1. A Licensed Nurse assessed RI #67 on 08/09/24, with no injuries identified and implemented 1:1 (one to one) supervision as an immediate intervention to protect other residents. RI #80 was assessed by a Licensed Nurse with no injuries identified and q 15 minute checks were initiated on 08/09/24. The Nursing Home Administrator was notified of the occurrence and a report was filed with the Department of Health and Human Services, Law Enforcement, and Adult Protective Services on 08/09/24. The Director of Nursing Services and/or designee reviewed and revised the plan of care for RI #67 and RI #80 on 08/09/24. 2. The Director of Nursing Services and/or designee interviewed residents with a BIMs score of 13-15 and completed a skin assessment on residents with a BIMs score of 12 or below by 12/13/24. No other concerns were identified. 3. The Nurse Practice Educator and/or designee educated employees on the Abuse Prohibition Policy and Procedure on 11/22/24. Additionally, the Administrator and/or designee will re-educate the Social Service Director and Interim Director of Nursing Services on obtaining other resident interviews and completing skin assessments on non-interviewable residents to ensure no	

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F 600	Continued From page 2 Cognitive loss/Dementia; 03/11/24-resident wandering into other residents rooms and attempting to take their belongings - became combative attempting to kick a nurse and medication cart when staff tried to remove her from the room; Resident continues to take things and hide linens in her room as of 06/18/24; Resident continues to take other peoples things as of 07/17/14; Resident evaluated by Psychiatric Nurse Practitioner on 07/17/24 related to increased forgetfulness with increase of Namenda medication. Resident #67 was admitted to the facility on 06/11/24 with diagnoses that included orthopedic aftercare following a surgical procedure. Review of a quarterly MDS assessment dated 08/05/24 documented Resident #67 had intact cognition. She had no behaviors. She had not wandered. She had not rejected care. She had an impairment on one lower extremity and ambulated using a wheelchair. Review of the care plan for Resident #67 dated 07/17/24 indicated no verbal or physical behaviors were documented on the care plan. The Initial Allegation Report dated 08/09/24 documented an allegation of resident to resident abuse. Resident #67 went into Resident #80's room and punched her for stealing her gum out of her room. Resident #67 was placed on one to one (1:1) observation, no injuries noted. Resident #80 was safe, did not fear harm, and no injuries were noted. Law enforcement and the Department of Social Services was notified on 08/09/24. The Investigation Report dated 08/15/24 related to the 08/09/24 allegation of	F 600	other instances of abuse have occurred by 12/16/24. 4. Beginning 12/16/24, the Director of Nursing Services and/or designee will randomly monitor a sample of 5 residents who exhibit behaviors twice weekly for eight weeks, and then weekly for four weeks to ensure a person centered behavioral care plan is in place to reduce behaviors and resident to resident altercations. The Nursing Home Administrator and/or designee will review the results of the audits in the monthly Quality Assurance Performance Improvement Committee meeting for one quarter to ensure compliance is achieved and sustained. Subsequent plans of correction will be implemented as necessary.	

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F 600	Continued From page 3	F 600		

resident to resident abuse involving Resident #67 and Resident #80 was substantiated.

An interview was conducted with Resident #67 on 11/04/24 at 10:15 AM. She stated another resident, Resident #80, wandered into her room on 08/09/24 and took her gum off the bed, and her phone and her coloring book pages out of her dresser. She reported that when she returned to her room the roommate, Resident #43, told her Resident #80 took her belongings. She went to Resident #80's room to get her things back and Resident #80 told her she did not have them. She stated Resident #80 swung at her so she instinctively punched her in the forehead with a closed fist. A staff member looked in Resident #80's dresser and gave her back her gum, phone and coloring book pages. She could not remember the staff member who retrieved her items. She noted that she got all the items back that Resident #80 had stolen from her. She recalled the police came and talked to her. Resident #67 also noted she had a 1:1 staff person who went with her everywhere for one week. She stated she was moved to the room she was currently in. She concluded that Resident #80 wasn't hurt but she was stunned because she wasn't expecting to be punched. She stated she did go back and apologize to Resident #80 for punching her in the head.

Nurse #11 wrote a statement dated 08/09/24 that documented the she was made aware of an issue by the PCA (Personal Care Attendant) worker. She went to Resident #80's room where she witnessed Resident #67 strike Resident #80. She separated the residents and performed skin checks on them both. No injuries were noted. The Administrator was made aware. Staff was

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F 600	Continued From page 4	F 600		

educated on abuse.

An interview was conducted with Nurse #11 on 11/08/24 at 8:20 AM. She stated her written statement was true and correct. She explained she was made aware of an issue between two residents by another staff member on 08/09/24, she could not remember who, and she went to Resident #80's room where she witnessed Resident #67 strike Resident #80. She stated she separated the residents and performed skin checks on both residents. She reported neither resident had been injured. She stated she notified the Administrator and the Unit Manager immediately. She noted that Resident #67 apologized to Resident #80, but that Resident #80 didn't remember she had been hit by Resident #67.

An interview was conducted with the Administrator on 11/08/24 at 8:36 AM. She stated she was notified on 08/09/24 immediately after the incident but could not remember who had called her when the altercation occurred between the two residents. She explained Resident #80, who had a history of wandering, had taken gum out of Resident #67's room and Resident #67 punched Resident #80. Resident #67 was put on 1:1 observation and Resident #80 was put on 15 minute checks immediately. She called the Social Worker to conduct investigation interviews, and the nurse completed a skin check on both residents with no injuries found. The allegation of abuse was substantiated.

An interview was conducted with the Social Worker on 11/08/24 at 8:41 AM. She stated she had left the facility on 08/09/24 but returned immediately when she was notified by the

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F 600	Continued From page 5	F 600		

Administrator that an altercation had occurred. She obtained written statements from the staff on duty. Nurse #11 had witnessed the altercation and provided a written statement. She interviewed Resident #67 and Resident #80 along with the roommate (Resident #49) of Resident #67. She stated when she interviewed Resident #80 the resident told her no one had hit her. She noted Resident #80 added she would have hit the person back had she been hit, and she had not. The Social Worker reiterated Resident #80 had no memory of the incident that quickly. She also interviewed Resident #67 who told her Resident #49, her roommate, informed her Resident #80 had taken her gum. When Resident #67 got her gum back, Resident #80 swung at her so she punched her in the forehead. The Social Worker noted that Resident #67 told her she had apologized to Resident #80.

In an additional interview with the Administrator by phone on 11/20/24 at 10:21 AM she stated after the incident occurred skin checks were performed on Resident #80 and Resident #67. Neither resident had been injured. The Administrator stated the facility had not completed any other resident interviews or assessed non-interviewable residents to ensure no other incidents of abuse had occurred. She explained that this was a targeted altercation between Resident #67 and Resident #80. She stated the plan the facility put in place going forward included monitoring of residents with known behaviors to determine if behaviors had increased and if new interventions were needed. The plan also included monitoring of any new residents who may have developed behaviors so that interventions could be put in place.

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F 684	Continued From page 6	F 684		
F 684 SS=E	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 observations, record review, and staff, Nurse Practitioner, and Consultant Pharmacist interviews the facility failed to 1.) follow a physicians order and apply an ace wrap to a residents left foot due to swelling sustained from a fall (Resident #17) and 2.) obtain a blood pressure prior to the administration of the antihypertensive medication Hydralazine 25 milligrams prescribed three times a day with parameters to hold the medication for systolic blood pressure less than 120 millimeters of mercury (Resident #5). This occurred for 2 of 2 residents reviewed for quality of care. Findings included. 1.) Resident #17 was admitted to the facility on 01/09/24 with diagnoses including dementia and repeated falls. A care plan dated 09/23/24 revealed Resident #17 was at risk for falls related to cognitive loss and lack of safety awareness. The goal of care was to remain free of injury. Interventions included in part to observe for changes in medical	F 684	1. RI #17 received a physician order on 12/11/24 to discontinue the use of the ace wrap to the left foot. RI #5 physician orders were modified to add blood pressure parameters to the Medication Administration Record according to the physician order on 11/7/24. 2. Nurse Manager and/or designee conducted a review to identify any other residents with physician orders for ace wraps by 12/11/24, one additional resident was identified and ACE wrap is applied per physician order. Nurse Managers and/or designee conducted a review of physician orders for blood pressure parameters to ensure relevant supplemental documentation of blood pressures were included on the Medication Administration Record by 12/15/24. 3. The Nurse Practice Educator and/or designee will re-educate Licensed Nurses on following and executing physician	12/18/24

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F 684	Continued From page 7 status and report to the physician. The Minimum Data Set (MDS) quarterly assessment dated 10/11/24 revealed Resident #17 was severely cognitively impaired. She required extensive assistance by staff with activities of daily living (ADL). She had falls since admission. She had no rejection of care. An incident report dated 11/04/24 at 6:45 AM revealed Resident #17 was found on the bathroom floor laying on her back in front of the toilet yelling for help. She stated she was trying to go to the bathroom. Shen denied hitting her head but complained of foot pain. The Physician was notified, and an x-ray of the foot was ordered. A physicians order dated 11/04/24 at 3:46 PM for Resident #17 revealed ace wrap (a compression bandage used to reduce swelling and improve blood flow and can be used to support an injured area) to the left foot as needed for swelling. An observation was conducted of Resident #17 on 11/04/24 at 4:05 PM. She was alert and oriented to person, and situation and did not appear to be in distress. Her left foot was observed with swelling on the anterior surface of the left foot and bruising noted to the 3rd and 4th toes. There was no ace wrap in place on the left foot. Resident reported pain in her left foot. During an interview on 11/04/24 at 4:10 PM Unit Manger #2 was notified of Resident #17's complaints of foot pain and was asked about the ace wrap. Unit Manager #2 stated she would notify Nurse #13 who was the assigned nurse. Review of the Medication Administration Record	F 684	orders as prescribed. Additionally, education with Licensed Nurses will include transcribing and documenting blood pressure parameters as ordered by the physician by 12/17/24. 4. Beginning 12/16/24, the Director of Nursing Services and/or designee will audit physician orders for 5 residents twice weekly for eight weeks, and then 5 residents once weekly for four weeks to ensure orders for ace wraps and parameters are executed as prescribed. The Nursing Home Administrator and/or designee will review the results of the audits in the monthly Quality Assurance Performance Improvement Committee meeting for one quarter to ensure compliance is achieved and sustained. Subsequent plans of correction will be implemented as necessary.	

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F 684	Continued From page 8	F 684		

(MAR) dated November 2024 revealed Resident #17 was administered Ibuprofen 800 milligrams on 11/04/24 at 4:40 PM for pain.

An observation was conducted on 11/05/24 at 9:15 AM of Resident #17. She was sitting in her wheelchair in her room. Her left foot was observed with swelling and bruising to the left toes. There was no ace wrap in place for swelling.

During an interview on 11/05/24 at 9:20 AM Nurse #13 stated mobile x-ray had just arrived at the facility and was preparing to do the x-ray for Resident #17. She did not say why the ace wrap had not been applied to Resident #17's foot for swelling.

A progress note dated 11/05/24 at 9:39 AM documented by Unit Manager #2 revealed Resident #17 had a fall yesterday. She complained of pain to the left foot with bruising. An x-ray was done and showed a fracture. Resident #17 would be sent to the Emergency department for further evaluation.

The hospital admission summary dated 11/05/24 at 10:50 AM revealed Resident #17 had a fall 11/04/24 and complaints of left foot pain. She did not hit her head and had no other complaints. There was significant bruising and swelling to her left foot. The final impression revealed Nondisplaced fractures of the first through fourth proximal phalanxes (bones of the toes) with questionable fractures of the distal third and fourth metatarsals (bones of the foot). Resident #17 had a walking boot placed to the left foot and was discharged back to the facility during the afternoon of 11/05/24.

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F 684	Continued From page 9	F 684		

An interview was conducted on 11/07/24 at 11:47 AM with the Nurse Practitioner. She reported that she evaluated Resident #17 around lunchtime on 11/04/24 the day of the fall. She stated at the time of the evaluation her foot was swollen and discolored but Resident #17 was still wheeling around in her wheelchair. She stated staff had already put in the order for an x-ray when she examined her. She stated she wrote an order to apply an ace wrap for swelling and support, and Ibuprofen for pain. She stated she expected the nurse to apply the ace wrap for foot swelling while waiting on the x-ray results.

Multiple attempts were made to contact Nurse #13 who was assigned to Resident #17 on 11/04/24 and 11/05/24 from 7:00 AM to 7:00 PM. There was no response.

During an interview on11/08/24 at 9:48 AM the Director of Nursing (DON) stated she didn't know about the order for the ace wrap until later on 11/05/24. She stated Nurse #13 who was on duty 11/04/24 and 11/05/24 was an agency nurse and was not returning her calls. She stated Nurse #13 should have been more in tune with Resident#17's needs and applied the ace wrap that was ordered as needed for swelling on 11/04/24. She stated due to Resident #17's dementia she had the Ibuprofen changed from as needed to scheduled for 24 hours while waiting on the x-ray, so her pain was addressed and managed. She reported Resident #17 was sent to the Emergency Department on 11/05/24 following the x-ray results. She stated she returned to the facility the same day with orders for a walking boot which she was wearing. She stated Nurse #13 should have applied the ace wrap to

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F 684	Continued From page 10	F 684		

Resident #17's foot on 11/04/24 and 11/05/24 due to swelling but indicated that did not occur. She stated staff training would be conducted on following physician orders.

2.) Resident #5 was admitted to the facility on 01/11/24 with diagnoses including hypertension.

A physicians order dated 09/04/24 for Resident #5 revealed Hydralazine oral tablets 25 milligrams (mg). Take 1 tablet (25 mg) by mouth in the morning, at noon, and at bedtime. Hold for systolic blood pressure less than 120 mm/hg.

Review of Resident #5's Medication Administration Record (MAR) dated September 2024 revealed Hydralazine oral tablets 25 milligrams (mg). Take one tablet (25 mg) by mouth in the morning, at noon, and at bedtime. The medication administration times were 8:00 AM, 12:00 PM, and 8:00 PM. The blood pressures were recorded on the MAR for the 8:00 AM dose but not for the 12:00 PM or 8:00 PM dose.

Review of Resident #5's electronic medical record revealed the following blood pressures recorded under the vital signs tab. Not including the 8:00 AM blood pressure readings the following blood pressures were recorded for September 2024. Missing dates had no blood pressures recorded for 12:00 PM or 8:00 PM.

09/06/24 11:17 PM 121/60 mmHg
09/07/24 10:37 AM 137/67 mmHg
09/08/24 11:15 AM 121/79 mmHg
09/10/24 06:49 PM 134/78 mmHg
09/12/24 11:39 AM 134/75 mm/Hg

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 11/20/2024

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F 684	Continued From page 11	F 684		

09/13/24 06:02 PM 138/73 mmHg
09/17/24 10:31 AM 144/78 mmHg
09/19/24 01:33 PM 123/74 mmHg
09/22/24 07:24 AM 128/68 mmHg
09/24/24 08:32 AM 144/78 mmHg
09/26/24 09:11 AM 134/74 mm/Hg
09/30/24 10:00 AM 115/62 mm/Hg

Review of Resident #5's Medication Administration Record (MAR) dated October 2024 revealed Hydralazine oral tablets 25 milligrams (mg). Take 1 tablet (25 mg) by mouth in the morning, at noon, and at bedtime. The medication administration times were 8:00 AM, 12:00 PM, and 8:00 PM. The blood pressures were recorded on the MAR for the 8:00 AM dose but not for the 12:00 PM or 8:00 PM dose.

Review of Resident #5's electronic medical record revealed the following blood pressures recorded under the vital signs tab. Not including the 8:00 AM blood pressure readings the following blood pressures were recorded for October 2024. Missing dates had no blood pressures recorded for 12:00 PM or 8:00 PM.

10/03/24 11:57 AM 128/62 mmHg
10/03/24 07:49 PM 132/74 mmHg
10/08/24 01:59 PM 128/78 mmHg
10/10/24 10:46 AM 132/76 mmHg
10/12/24 11:36 AM 123/78 mmHg
10/13/24 11:57 AM 134/77 mmHg
10/17/24 12:02 PM 132/74 mmHg
10/17/24 10:24 PM 130/71 mmHg
10/18/24 03:15 AM 130/71 mmHg
10/19/24 11:14 AM 127/76 mmHg
10/20/24 11:08 AM 122/74 mmHg
10/20/24 07:07 PM 128/65 mmHg
10/22/24 12:14 PM 133/64 mmHg

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 11/20/2024

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 12	F 684		

10/27/24 09:31 PM 132/76 mmHg
10/31/24 01:40 PM 140/76 mmHg

Review of Resident #5's Medication Administration Record (MAR) dated November 2024 revealed Hydralazine oral tablets 25 milligrams (mg). Take 1 tablet (25 mg) by mouth in the morning, at noon, and at bedtime. The medication administration times were 8:00 AM, 12:00 PM, and 8:00 PM. The blood pressures were recorded on the MAR for the 8:00 AM dose but not for the 12:00 PM or 8:00 PM dose.

Review of Resident #5's electronic medical record revealed the following blood pressures recorded under the vital signs tab. Not including the 8:00 AM blood pressure readings the following blood pressures were recorded for November 2024. Missing dates had no blood pressures recorded for 12:00 PM or 8:00 PM.

11/01/24 12:56 PM 143/78 mmHg
11/04/24 11:37 AM 126/64 mmHg
11/07/24 08:05 PM 140/74 mmHg

The Minimum Data Set (MDS) significant change assessment dated 10/17/24 revealed Resident #5 was cognitively intact. He required assistance with activities of daily living (ADLs). He had no rejection of care.

During a phone interview on 11/07/24 at 02:57 PM the Consultant Pharmacist stated she addressed adding blood pressure orders on the MAR prior to the administration of Hydralazine for Resident #5 in her monthly pharmacy reviews. She reported that she would keep addressing to

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 11/20/2024

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PEMBROKE CENTER	310 E WARDELL DRIVE PEMBROKE, NC 28372

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F 684	Continued From page 13 add blood pressure checks monthly until she saw that the issue was resolved. She indicated Resident #5's 8:00 AM blood pressures were stable, and the physician would most likely discontinue checking a blood pressure three times a day. But this issue needed to be addressed. She indicated hydralazine worked by relaxing the blood vessels which could lead to a drop in blood pressure which was why parameters were added. During an interview on 11/07/24 at 03:03 PM Unit Manger #1 stated she notified the Physician today and the Physician stated to continue to administer Hydralazine 25 mgs three times a day and to check the blood pressure prior to administration. He reported he would evaluate Resident #5 on his next visit on 11/08/24. During an interview on 11/08/24 at 03:06 PM the Director of Nursing (DON) stated she began working in the facility in October 2024. She stated she was not aware of the Hydralazine order for Resident #5 and not aware blood pressures were not being checked prior to administration. She stated when the medication order was entered into the electronic medical record the blood pressure checks were not initiated and did not reflect on the MAR. She stated it would be corrected, and education would be provided to staff to enter blood pressure checks on the MAR when entering orders with parameters. An observation was conducted of Resident #5 on 11/08/24 at 3:30 PM. He was observed in his wheelchair in the hallway. He was interacting with other residents and staff. He was in no distress.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices	F 689		12/18/24

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 11/20/2024

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F 689	Continued From page 14 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 resident, staff, Nurse Practitioner and Physician interviews, the facility failed to provide care safely to a dependent resident when Resident #46 fell off the bed during care on 7/30/24 and 9/20/24 resulting in minor injuries. This deficient practice affected 1 of 3 residents reviewed for falls. Findings included: Resident #46 was admitted on 5/15/23 with diagnosis of history of neoplasm of brain, hemiparesis (paralysis on one side of the body) left dominant side, stroke, weakness, and seizures. Review of Resident #46's quarterly Minimum Data Set (MDS) assessment dated 6/13/24 indicated the resident was cognitively intact, had impairment of the upper and lower extremities on one side, required extensive assistance of 2 people for bed mobility, total assistance of 2 people with transfers, toileting and bathing. Resident #46's height was recorded as 63 inches (5 feet 3 inches) and weighed 266 pounds. Resident #46 was coded as had pain in past 5 days and received scheduled and as needed pain	F 689	1. On 12/13/24, a Licensed Nurse assessed RI #46 and reviewed the plan of care and nursing kardex to ensure the level of assistance necessary to safely provide care was accurate and verified bolters were in place. 2. Nurse Managers and/or designee reviewed dependent residents to ensure the plan of care and nursing kardex reflected the assistance level required to provide safe care with activities of daily living by 12/15/24. Concerns identified were corrected by updating the plan of care and kardex. Additionally, a review was conducted of residents with bolters to verify bolters are in place according to the care plan. 3. Nurse Practice Educator and/or designee will re-educate nursing staff on the Safe Resident Handling and Accident/Incident Policy and Procedure with specific emphasis on adhering to the plan of care for the level of assistance required to safely provide care for dependent residents, bolsters are in	

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	345409	A. BUILDING _____ B. WING _____	C 11/20/2024

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F 689	Continued From page 15 medication. Resident #46 received opioid medication. Review of Resident #46's care plan revealed a focus dated 6/14/23 which indicated a risk for falls due to impaired mobility due to muscle weakness, history of seizures, anemia and hemiparesis. The goal indicated resident will have no falls with injury for 90 days. Interventions included placing the bed in low position and fall mat to right side of bed. Further review of Resident #46's care plan revealed a focus initiated on 6/19/23 and last revised on 6/24/24 of at risk for decreased ability to perform bathing, grooming, personal hygiene, bed mobility, and toileting related to limited mobility and hemiparesis. The goal indicated Resident #46's care needs will be anticipated and met throughout the next review period. The care plan included a 7/19/23 intervention to provide the resident with total assistance of 2 for bed mobility. Review of Resident #46's July 2024 physician's orders included the following pain medications: gabapentin 100 milligrams (mg) three times per day for neuropathic pain, baclofen 10 mg four times per day for muscle spasms, and as needed (PRN) oxycodone-acetaminophen 5-325 mg. a. A review of Resident #46's electronic health record revealed a change in condition progress note dated 7/30/24 at 7:36 PM written by Nurse #11. The nursing progress note indicated the nurse was made aware at 7:10 PM that the resident had a fall during patient care. The resident was observed lying face down on a fall mat when the writer entered the room. An abrasion was noted to the left upper ear and	F 689	place, if ordered, and the assessment is accurately documented by 12/17/24. 4. Beginning 12/16/24, the Nurse Managers and/or designee will randomly audit dependent residents to ensure the assistance level is implemented according to the plan of care and bolsters are in place, if ordered, and assessment is accurately documented for 5 residents twice weekly for eight weeks, and then 5 residents once weekly for four weeks. The Director of Nursing Services and/or designee will review the results of the audits in the monthly Quality Assurance Performance Improvement Committee meeting for one quarter to ensure compliance is achieved and sustained. Subsequent plans of corrections will be implemented as necessary.	

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	345409	A. BUILDING _____ B. WING _____	C 11/20/2024

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F 689	Continued From page 16	F 689		

bruising to the right forehead. The primary care provider was notified with recommendation made to start neurological checks and monitor the resident.

An interview was conducted on 11/6/24 at 11:04 AM with Nurse Aide (NA) #3 who stated she worked 3:00 PM to 11:00 PM shift and was assigned to Resident #46 on 7/30/24. NA #3 stated Resident #46 required total care and was totally dependent. NA #3 indicated Resident #46 required 2-person assistance with care but sometimes 2 people weren't available. NA #3 stated the evening of the incident, she came in late for her shift and the nurse informed her they were short staffed. NA #3 went to check on Resident #46 and she stated she required incontinence care and needed the lift pad removed from under her. NA #3 stated she knew she needed to go and try to find someone to help but Resident #46 insisted she needed care. NA #3 stated she decided she could provide the care for Resident #46 by herself, so she proceeded to provide incontinent care and remove the lift pad. NA #3 stated the bed was at about the height of her hips and she (NA #3) was 5 feet 6 inches tall. NA #3 stated she was finishing with the care when she turned Resident #46 onto her right side away from her when the resident rolled off the bed onto the fall mat. NA #3 indicated Resident #46 hit her ear on the bedside table but did not complain of pain. NA #3 stated she realized afterwards that she should not have tried to provide the care by herself since she knew from the care plan that Resident #46 required 2-person assistance.

Review of Resident #46's electronic health record revealed a Nurse Practitioner note dated 7/30/24

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 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 17	F 689		

at 7:30 PM. The progress note stated Resident #46 was seen via telehealth for a staff witnessed fall that occurred at 7:18 PM. Resident was receiving incontinence care by the aide when she fell out of bed to the floor. Per the nurse, the physical assessment was negative with no evidence of physical injury to the head or the bony structures. Resident #46 sustained an abrasion to her left ear that was cleaned with normal saline, and an order was provided for treatment.

A skin evaluation note dated 7/31/24 by Nurse #11 revealed Resident #46 had a bruise to the upper right forehead and an abrasion to the left ear.

Review of Resident #46's physician orders revealed an order dated 7/31/24 to cleanse the upper ear abrasion with normal saline and pat dry. Apply triple antibiotic ointment to the wound bed and cover with a dry dressing every day shift and as needed.

A transfer note dated 7/31/24 at 5:08 PM by Nurse #11 revealed Resident #46 was transferred to the hospital due to a fall that occurred on 7/30/24.

A change in condition note dated 7/31/24 at 5:57 PM by Nurse #11 revealed Resident #46 requested to be sent to the hospital for evaluation due to a fall that occurred on 7/30/24 with new onset of pain.

Review of an Emergency Department (ED) Report dated 7/31/24 revealed Resident #46 presented with a chief complaint of a fall and

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 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 18	F 689		

stated she fell out of bed while staff were changing her. The CT scans and x rays were negative. There were no changes to Resident #46's pain medication or medical treatment required for the injuries.

A nursing progress note dated 7/31/24 at 6:44 PM by Nurse #11 revealed the nurse at the hospital reported the computed tomography (CT) scans of the head and spine were negative and x rays of the left hand, and shoulder were negative.

Review of Resident #46's MAR from following the fall on 7/30/24 through August 2024 indicated her pain medication was effective.

An interview was conducted on 11/6/24 at 4:30 PM with Nurse #11. Nurse #11 stated she was no longer employed at the facility. Nurse #11 stated she was assigned to Resident #46 on 7/30/24. Nurse #11 stated Resident #46 did not voice any pain initially but reported increased pain after the fall that occurred on 7/30/24 and she went to the ED for evaluation. Nurse #11 indicated Resident #46 required 2 or 3 persons assist for bed mobility and incontinent care. Nurse #11 stated it was frequently hard to find a second person to assist with Resident #46's care due to staffing issues. Nurse #11 stated she wasn't sure what interventions were implemented to prevent further falls.

An interview was conducted on 11/6/24 at 11:45 AM with the Physical Therapist (PT). PT stated Resident #46 was dependent for care and required 2- person assistance with transfers and bed mobility. PT stated Resident #46 was last evaluated on 8/1/24, regarding bed mobility. PT stated Resident #46 was evaluated as requiring

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 11/20/2024

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F 689	Continued From page 19	F 689		

2-person assistance with bed mobility and that therapy services were not indicated.

Review of Resident #46's electronic health record revealed an 8/2/24 physician order for bolsters to the bed to aid in positioning. Monitor for placement and function every shift.

Review of Resident #46's care plan revealed an intervention dated 8/5/24 to apply bolsters to the bed to aid with repositioning when resident was in her bed.

A transfer assessment dated 9/13/2024 at 5:01 PM was completed by Unit Manager #1. The assessment indicated Resident #46 required at least 2 staff with repositioning.

b. A change in condition note dated 9/20/24 at 7:09 AM written by Unit Manager #1 indicated the nurse was notified by the Nursing Assistant that Resident #46 rolled out of bed. The Nursing Assistant stated Resident #46 rolled out of bed but was aided to floor with help from the nursing assistant. Resident #46 was assessed with no injuries or complaints of pain or discomfort.

An interview was conducted on 11/5/24 at 2:30 PM with Unit Manager #1. Unit Manager #1 stated Resident #46 required 2-person assistance with bed mobility and was totally dependent for incontinence care. Unit Manager #1 stated Resident #46 had falls in which she rolled out of bed, but she did not recall the specifics or the interventions that were implemented to prevent further falls.

An interview was conducted on 11/5/24 at 3:30 PM with NA #2 assigned to Resident #46 on

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 11/20/2024

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 20	F 689		

9/20/24. The NA indicated she worked 7:00 PM to 7:00 AM shift and was familiar with Resident #46's care. The NA stated Resident #46 required 2- person assist for bed mobility and incontinence care and was total care. NA #2 indicated Resident #46 required incontinence care regularly at night. NA #2 indicated on 9/20/24, she was on the left side of the bed providing care by herself to Resident #46. NA #2 stated she was unable to find someone to assist her and thought she could provide the care safely. NA #2 stated she rolled the resident onto her right side when Resident #46 started sliding off the bed. The NA indicated the bolsters were not attached to the bed properly and the resident was sliding off the bed. The NA indicated she tried to grab the resident and prevent her from hitting the floor. NA #2 stated Resident #46 did not complain of pain at the time but had some pain later. NA #2 indicated she reported to the nurse what happened, and the resident was assessed and assisted back to bed with 2- person assist. NA #2 indicated that since that incident occurred, she was retrained regarding having 2- person assist to provide care. NA #2 indicated that since the fall occurred, they tried to make sure there were 2- staff to provide care but sometimes there wasn't enough staff.

A nursing note dated 9/24/24 at 11:51 AM revealed Resident #46 was evaluated by the Nurse Practitioner due to the fall and complaint of pain. A chest x ray was ordered.

Review of a chest x ray obtained on 9/24/24 revealed a rib fracture was not seen but the report was not definitive.

Review of a hospital Emergency Department

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 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 21	F 689		

report dated 9/25/24 indicated Resident #46 presented with a chief complaint of a fall. The resident was brought to the Emergency Department for evaluation after a fall 5 days ago. The resident rolled out of bed. An X ray obtained at the nursing facility could not rule out a rib fracture. The CT scan of the chest was completed with no acute fractures and the resident was discharged to the nursing facility with no new orders or changes to her care.

Review of Resident #46's MAR from following the fall on 9/20/24 through 9/30/24 indicated her pain medication was effective.

An interview was conducted with Resident #46 on 11/5/24 at 10:30 AM. Resident #46 stated 1 person was providing care when both falls occurred. Resident #46 stated she was supposed to have 2 people to provide her care. In July, when the fall occurred, 1 Nursing Assistant (NA) #3 was providing her care and the NA could not stop her from falling on the floor. Resident #46 stated during both falls, she fell off the bed to the right side and went to the emergency room for evaluation. Resident #46 stated the second fall that occurred in September was with NA #2 and she (NA #2) attempted to stop her from rolling off the bed. After the second fall in September, Resident #46 stated she had bruising on her side rib area and the Nurse Practitioner ordered a chest x ray to make sure she had not fractured her ribs. Resident #46 stated the chest x ray was negative for rib fracture. Resident #46 stated there weren't bolsters on the bed when she fell the second time.

An interview was conducted with the Physician on 11/7/24 at 9:31 AM. The Physician stated due to

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	345409	A. BUILDING _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 22 Resident #46's body size and condition, she required 2 strong staff members to provide care. The Physician further stated that Resident #46 received sedating medications and that would specifically cause her to need increased assistance. The Physician stated protective measures including reeducation of staff that the resident must have 2 or more staff to provide her care were implemented following the first fall. The Physician indicated that since Resident #46 had a second fall, the measures that were implemented initially were not effective and had the potential for harm to the resident. An interview was conducted with the Director of Nursing (DON) on 11/7/24 at 2:30 PM. The DON stated she started in the position at the facility in October 2024. The DON stated she expected that staff keep the residents safe during care. The DON stated she expected the staff to work together and if a resident was a 2 person assist, they must use 2 people. If the Nurse Aide was not able to find another NA to assist with care, the DON stated she expected the NA to report this to the nurse.	F 689		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in	F 725		12/18/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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PEMBROKE CENTER	310 E WARDELL DRIVE PEMBROKE, NC 28372

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F 725	Continued From page 23 accordance with the facility assessment required at §483.71. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on record review, resident, staff, Nurse Practitioner and Physician interviews, the facility failed to provide sufficient nursing staff to ensure the necessary supervision and assistance level was implemented in accordance with the resident's plan of care for the safe provision of activities of daily living care for a dependent resident. This deficient practice affected 1 of 3 residents reviewed for sufficient nursing staff. Findings included: This tag is cross referenced to: F689: Based on record review, resident, staff, Nurse Practitioner and Physician interviews, the facility failed to provide care safely to a dependent resident when Resident #46 fell off the bed during care on 7/30/24 and 9/20/24 resulting in minor injuries. This deficient practice affected 1 of 3 residents reviewed for falls.	F 725	1. Nursing Home Administrator and Director of Nursing Services reviewed the Facility Assessment to identify and implement staffing needs for each unit to ensure appropriate staffing levels to provide the necessary supervision and assistance level in accordance with the plan of care for safe provision of activities of daily living for dependent residents. On 12/13/24, a Licensed Nurse assessed RI #46 and reviewed the plan of care and nursing kardex to reflect the level of assistance necessary to safely provide care verified bolters were in place. 2. On 12/13/24, the Nursing Home Administrator and/or designee reviewed staffing schedules in the last 14 days and made adjustments as needed to staffing levels to ensure sufficient staff to provide	

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 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 725	Continued From page 24 An interview was conducted with Resident #46 on 11/5/24 at 10:30 AM. Resident #46 stated she was supposed to have 2 people to provide her care, but the facility did not always have enough staff available, especially on night shift (11:00 PM to 7:00 AM). Resident #46 stated there was frequently only 1 Nurse Aide (NA) providing her care and she was afraid of falling again. An interview was conducted on 11/5/24 at 3:30 PM with NA #2. The NA indicated she worked 7:00 PM to 7:00 AM shift and there were residents on her assignment that required 2-person assistance for bed mobility and were total care for incontinence care. NA #2 stated there were times when she was unable to find someone to assist her and she would provide the care by herself rather than having the residents wait. NA #2 stated the nurses were busy with their own duties. NA #2 stated she tried to make sure there were 2- staff to provide care but sometimes there wasn't enough staff. An interview was conducted on 11/6/24 at 11:04 AM with NA #3 who stated she worked 3:00 PM to 11:00 PM shift. NA #3 indicated she had several residents on her assignment that required 2-person assistance with care but sometimes 2 people weren't available due to staffing issues and that the facility was frequently short staffed. NA #3 stated the facility used a lot of agency staff. NA #3 indicated the facility staffed with 3 or 4 NAs on night shift, however due to the acuity of the residents, it was not sufficient. NA #3 stated with her residents that required 2-person assistance, she knew she needed to go and try to find someone to help but there were times she decided to try to provide the care by herself so	F 725	the necessary supervision and assistance level for dependent residents. The Director of Nursing Services and/or designee reviewed other residents deemed as dependent to ensure the plan of care and nursing kardex reflects the level of assistance needed to provide safe resident handling. 3. Nursing Home Administrator will re-educate the Director of Nursing Services, Staffing Coordinator, and Licensed Nurses on ensuring sufficient staff to provide the necessary supervision and assistance level in accordance with the plan of care for safe provision of care for dependent residents by 12/17/24. 4. Beginning 12/16/24, the Nursing Home Administrator and/or designee will review staffing schedules twice weekly for eight weeks, then weekly for four weeks, to ensure sufficient staffing to provide necessary supervision and level of assistance according to the plan of care. The Nursing Home Administrator and/or designee will review the results in the monthly QAPI meeting for one quarter to ensure compliance is achieved and sustained. Subsequent plans of correction will be implemented as necessary.	

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F 725	Continued From page 25	F 725		

the resident wouldn't have to wait. NA #3 stated there were staffing shortages at the facility for a while and agency staff were utilized to help fill the staffing needs. NA #3 stated the agency staff often did not show up, did not assist the other NAs with care for their assigned residents and she often assisted the agency staff's assigned residents when she observed call lights going off.

An interview was conducted on 11/6/24 at 4:30 PM with Nurse #11. Nurse #11 indicated there were residents on her assignment that required 2- or 3-persons assistance for bed mobility and incontinent care, but it was frequently hard to find a second or third person to assist due to staffing issues so they just did the best they could. Nurse #11 stated agency staff sometimes did not show up for assigned shifts and it was difficult to find replacements.

An interview was conducted via phone with Nurse #6 on 11/7/24 at 11:14 AM. Nurse #6 stated she was an agency nurse that had been working at the facility for the past 8 weeks on the 7:00 PM to 7:00 AM shift. Nurse #6 stated staffing at the facility was not always sufficient to meet the needs of the residents and that the number of NAs working on the 11:00 PM to 7:00 AM shift varied. Nurse #6 indicated there were several residents that required 2-person assistance, it was difficult for the NAs to find someone to help them, and she was busy with her own duties on her shift.

An interview was conducted with NA #4 on 11/7/24 at 11:30 AM. NA #4 indicated it was hard to find someone to help with her residents that required 2-person assistance. NA #4 indicated it would put her behind on her assignment trying to

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F 725	Continued From page 26 find someone to help. NA #4 stated when providing care to her residents in bed, she provided the care by herself even though she knew the residents required 2-person assistance due to not having sufficient staffing. NA #4 stated she realized providing the care by herself put her and the resident at risk of getting hurt. An interview was conducted with the Nursing Scheduler/Payroll Manager on 11/7/24 at 10:00 AM. The Nursing Scheduler/Payroll Manager revealed she was responsible for the staffing and scheduling for the facility. The Nursing Scheduler/Payroll Manager indicated the facility should be scheduled with 5 Nursing Assistants (NAs) on 2nd shift (3:00 PM to 11:00 PM) and 4 NAs on 3rd shift (11:00 PM to 7:00 AM) according to what she had been told by the previous Director of Nursing. The Nursing Scheduler stated she tried to adhere to this but there were times she could not staff this. There were last-minute call outs and no call no show instances and it was challenging to find replacements. The nurse in charge on the shift was expected to try to find a replacement for call outs on the next shift. An interview was conducted with the Director of Nursing (DON) on 11/7/24 at 2:30 PM. The DON stated the nurses were ultimately responsible for the care that the NAs provide on the shift and ensuring that the care was provided safely. The DON indicated she was new to the area, was trying to get a feel for which staffing agencies were reliable, and which were not. The DON stated she intended to address the issues with staffing and would be reviewing staffing daily.	F 725		
F 727 SS=D	RN 8 Hrs/7 days/Wk, Full Time DON	F 727		12/18/24

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F 727	Continued From page 27 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 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 record review and staff interviews, the facility failed to provide 8 consecutive hours of Registered Nurse (RN) coverage on 5 of 60 days reviewed. Findings included: Review of the PBJ (Payroll Based Journal) Staffing Data Report Fiscal Year - Quarter 2, 2024 (January 1-March 31, 2024) documented the facility had no RN coverage on 02/18/24, 02/24/24, 03/02/24, 03/03/24, 03/16/24, and 03/17/24. In an interview with the Nursing Scheduler/Payroll Manager on 11/07/24 at 10:15 AM she confirmed there was no RN coverage in the building for 8 hours on the following dates: 02/18/24, 03/02/24, 03/03/24, 03/16/24, and 03/17/24. She examined the staff payroll punches for the noted dates and was surprised to discover Agency Nurse #14 and	F 727	1. The Administrator and/or designee verified 8 consecutive hours of RN coverage was scheduled on 11/5/24. 2. On 12/13/24, the Nursing Home Administrator and/or designee reviewed the Nursing schedules in the last 14 days to verify 8 consecutive hours of RN coverage was implemented. No concerns were identified. 3. The Market Regulatory Specialist and/or designee will educate the Nursing Home Administrator, Director of Nursing Services, and Staffing Coordinator on ensuring the center is providing 8 hours of consecutive RN coverage daily by 12/17/24. 4. The Nursing Home Administrator and/or designee will audit the Nursing	

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F 727	Continued From page 28 Agency Nurse #15 that she thought were RNs were actually LPNs (Licensed Practical Nurses) leaving the facility with no RN coverage on 5 days. She reported that the facility did have RN coverage in the building for 12 hours on 02/24/24. She explained Nurse #13 had worked on 02/24/24 and took off time later in the week to compensate because she was salaried and did not punch the time clock. She stated she did not know why the PBJ report documented 02/24/24 as "no RN hours" but guessed it was because Nurse #13 did not punch the time clock. She explained that a person at the corporate level submitted the data for the PBJ report and she was not familiar with that process. In a phone interview with Nurse #13 on 11/7/24 at 11:40 AM she stated that she kept a calendar in her phone and confirmed that she had worked for 12 hours at the facility on 02/24/24 and in return had taken compensatory time off on 02/26/24 and 02/27/24. She explained that she was salaried and did not punch in and out. She confirmed that she was a Registered Nurse. She stated she no longer worked at the facility but had transferred to a sister facility in Pennsylvania. In an interview with the Administrator on 11/08/24 at 10:30 AM she stated she was not sure why the PBJ report was incorrect but would check with corporate to resolve any data entry issues. She explained she had not realized that the agency had sent LPNs instead of RNs on the days when there was no RN in the building. She assumed the agency had sent RNs because that is what the facility had requested in their posting. She explained that going forward all nursing titles would be included on the working schedule (LPN vs RN). Also, the Director of Nursing and the	F 727	schedules and kronos system twice weekly for eight weeks and then weekly for four weeks to validate 8 consecutive hours of RN coverage is maintained daily. The Nursing Home Administrator and/or designee will review the results of these audits in the Quality Assurance Performance Improvement Committee for one quarter to ensure substantial compliance has been achieved and sustained. Subsequent plans of corrections will be implemented as necessary.	

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F 727	Continued From page 29 Scheduler would review the schedule each morning to ensure there was an RN in the building for 8 consecutive hours every day.	F 727		
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	F 756		12/18/24

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F 756	Continued From page 30 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. This REQUIREMENT is not met as evidenced by: Based on record review, and staff and Consultant Pharmacist interviews the facility failed to act on the Pharmacist recommendations to clarify the dose of an antihypertensive medication (Hydralazine 25 milligrams) and to add blood pressure checks prior to administration. This occurred for 1 of 5 residents (Resident #5) reviewed for medication administration. Findings included. Resident #5 was admitted to the facility on 01/11/24 with diagnoses including hypertension. The Consultant Pharmacists monthly medication regimen review dated 07/12/24 for Resident #5 revealed the following order recommendation. Hydralazine oral tablets 25 milligrams (mg). Take 1 tablet (25 mg) by mouth in the morning, at noon, and at bedtime. Hold for systolic blood pressure less than 120 mm/hg (millimeters of mercury). The order does not have a vital signs order attached. The Pharmacist recommended to please review and update. Review of the Medication Administration Record (MAR) dated July 2024 and August 2024 revealed no blood pressure order was added to check the blood pressure prior to administering Hydralazine 25 mgs to Resident #5.	F 756	1.The Director of Nursing Services reviewed the pharmacy recommendation for RI #5 and the physician order was clarified and modified to add blood pressure parameters to the Medication Administration Record as prescribed by the physician on 11/5/24. 2. The Nurse Managers and/or designee reviewed the pharmacy recommendations in the last 30 days to ensure the recommendations were acted upon timely by 12/15/24. Any identified concerns were addressed as needed. 3. The Nurse Practice Educator and/or designee will educate Licensed Nurses on follow up and execution of pharmacy recommendations in a timely manner by 12/17/24. 4. Beginning 12/16/24, the Nurse Managers and/or designee will randomly audit 5 residents for pharmacy medication regimen reviews twice weekly for eight weeks, and then weekly for four weeks to ensure timely follow up. The Director of Nursing Services and/or designee will review the results of these audits in the Quality Assurance Performance Improvement Committee for one quarter to ensure substantial compliance has	

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F 756	Continued From page 31 A physicians order dated 09/04/24 for Resident #5 revealed Hydralazine oral tablets 25 milligrams (mg). Give 2 tablets by mouth three times a day for hypertension. Take 1 tablet (25 mg) by mouth in the morning, at noon, and at bedtime. Hold for systolic blood pressure less than 120 mm/hg. The Consultant Pharmacists monthly Medication Regimen Review dated 09/11/24 for Resident #5 revealed to clarify the dose of Hydralazine 25 milligrams. Give 2 tablets by mouth three times a day for hypertension. Take 1 tablet (25 mg) by mouth in the morning, at noon, and at bedtime. Hold for systolic blood pressure less than 120 mm/hg. The clarification request documented that the above order was confusing. Was the dose 25 mg three times a day or 50 mg three times a day. The Pharmacist recommended to please review and clarify the dose. Review of the physician orders for Resident #5 dated September 2024 revealed the Hydralazine order was not clarified. Blood pressure orders prior to administration were not added. The Consultant Pharmacists monthly medication regimen review of items that were pending and needing a final response for the period of 10/01/24 and 10/10/24 for Resident #5 revealed to clarify the dose of Hydralazine 25 milligrams three times a day. The above order was confusing. Is the dose 25 mg three times a day or 50 mg three times a day. The Pharmacist recommended to please review and clarify the dose. Review of the physicians orders for Resident #5 dated October 2024 revealed the Hydralazine order was not clarified. Blood pressure orders	F 756	been achieved and sustained. Subsequent plans of corrections will be implemented as necessary.	

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F 756	Continued From page 32	F 756		

prior to administration were not added.

The Minimum Data Set (MDS) quarterly assessment dated 10/17/24 revealed Resident #5 was cognitively intact. He required assistance with activities of daily living (ADL). He had no rejection of care.

During a phone interview on 11/07/24 at 02:57 PM the Consultant Pharmacist stated she addressed the Hydralazine order for Resident #5 in her monthly pharmacy reviews beginning in July 2024. She stated she initially requested blood pressure orders to be added to the Medication Administration Record (MAR) in July 2024. She stated according to the MAR blood pressure checks had not been added prior to administering the medication. She stated she addressed the Hydralazine order again in September 2024 because the order was revised 09/04/24 and the order was confusing, so she requested a dose clarification. She reported that according to the resident s medical record the dose clarification or adding blood pressure checks had not been done. She stated she would continue to address the dose clarification and blood pressure orders monthly until she saw that the issue was resolved. She indicated Resident #5's 8:00 AM blood pressures were stable, and the physician would most likely discontinue checking a blood pressure three times a day, but the issue needed to be addressed. She stated the dose needed clarification as well and as of October 2024 it had not been clarified. She stated the Pharmacy just started servicing this facility in June 2024 and she knew there had been some staff turnover which could have caused some delay in acting on the Pharmacy reviews. She stated she expected that this medication would

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F 756	Continued From page 33 have been clarified sooner and blood pressure checks added. During an interview on 11/07/24 at 03:03 PM Unit Manger #1 stated she notified the Physician today and the Physician stated the order should be for Hydralazine 25 mgs three times a day. She reported that was the dose Resident #5 had been receiving all along. She stated the Physician instructed her to continue to administer Hydralazine 25 mgs three times a day and to check the blood pressure prior to administration. He reported he would evaluate Resident #5 on his next visit on 11/08/24. During an interview on 11/08/24 at 03:06 PM the Director of Nursing (DON) stated she began working in the facility in October 2024. She stated she was not aware of the Pharmacy recommendation and request to clarify the Hydralazine order for Resident #5 and not aware blood pressures were not being checked prior to administration. She stated the previous DON would have been responsible for the July through September Pharmacy reviews. She stated she was responsible for the October Pharmacy reviews but was still trying to determine and prioritize what needed to be corrected. She reported now that she was aware that all of the monthly Pharmacy reports were not being addressed, she would review them and ensure they were getting done.	F 756		
F 757 SS=E	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any	F 757		12/18/24

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F 757	Continued From page 34 drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff, the Nurse Practitioner, and the Consultant Pharmacist interviews the facility failed to accurately transcribe an antihistamine order (Hydroxyzine 25 milligrams) prescribed as needed for itching. This resulted in the resident receiving the medication daily instead of as needed. The resident experienced no outcome from receiving the medication. This occurred for 1 of 5 residents (Resident #59) reviewed for medication administration. Findings included. Resident #59 was admitted to the facility on 09/11/24 with diagnoses including paraplegia and dementia.	F 757	1. Licensed Nurse received an order to discontinue RI #59□s antihistamine medication on 11/8/24. 2. The Nurse Managers and/or designee reviewed hospital discharge orders for active new admissions and/or readmissions in the last 30 days to ensure physician orders were transcribed accurately by 12/13/24. Any identified concerns were clarified with the physician. 3. The Nurse Practice Educator and/or designee will educate Licensed Nurses on transcribing physician orders accurately to prevent unnecessary medications by 12/17/24.	

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F 757	Continued From page 35 Review of the hospital after visit summary dated 09/11/24 for Resident #59 revealed an order for Hydroxyzine 25 milligrams (mg) administer at bedtime as needed for itching. The Minimum Data Set (MDS) admission assessment dated 09/18/24 revealed Resident #59 was cognitively intact. He required extensive assistance with activities of daily living. He had no rejection of care. Review of the Medication Administration Record (MAR) dated September 2024 for Resident #59 revealed Hydroxyzine 25 milligrams at bedtime for itching. The medication was scheduled for administration at 9:00 PM and was administered to Resident #59 nightly from 9/11/24 through 9/30/24. Review of the Medication Administration Record (MAR) dated October 2024 for Resident #59 revealed Hydroxyzine 25 milligrams at bedtime for itching. The medication was scheduled for administration at 9:00 PM and was administered to Resident #59 nightly from 10/01/24 through 10/31/24. Review of the Medication Administration Record (MAR) dated November 2024 for Resident #59 revealed Hydroxyzine 25 milligrams at bedtime for itching. The medication was scheduled for administration at 9:00 PM and was administered to Resident #59 nightly from 11/01/24 through 11/06/24. An interview was conducted on 11/07/24 at 11:47 AM with the Nurse Practitioner. She stated Hydroxyzine 25 milligrams was considered a low dose. She stated it was not sedating and would	F 757	4. Beginning 12/16/24, the Nurse Managers and/or designee will audit hospital discharge orders for admissions and/or readmissions twice weekly for eight weeks, and then weekly for four weeks to ensure accurate transcription of medications. The Director of Nursing Services and/or designee will review the results of these audits in the Quality Assurance Performance Improvement Committee for one quarter to ensure substantial compliance has been achieved and sustained. Subsequent plans of corrections will be implemented as necessary	

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 11/20/2024

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 757	Continued From page 36	F 757		

cause no harm to Resident #59. She indicated she was not aware he was receiving Hydroxyzine daily instead of as needed.

During an interview on 11/07/24 at 1:00 PM Unit Manger #1 stated new admissions orders were entered into the residents electronic medical record by the unit managers or the admitting nurse. She stated the process included that medication order entries were reviewed three times. Following admission, orders were reviewed by the nurse or unit manager, the Pharmacist during the admission review and by the corporate liaison to ensure accuracy. She stated new admission orders were transcribed from the residents hospital after visit summary. She indicated the order was entered as a scheduled medication instead of as needed. She stated she checked Resident #59's medication order for Hydroxyzine and there had been no changes made since admission in the frequency of the order, and it should have been entered to give as needed. She stated she notified the Physician of the medication discrepancy. He instructed her to leave the medication as it is for today and he would evaluate Resident #59 tomorrow on 11/08/24 when he returned to the facility.

During an interview and observation on 11/07/24 at 2:00 PM Resident #59 was observed lying in bed watching TV. He was alert and oriented to person, and place. He stated he did not have any problems with itching and did not appear to be drowsy. He was not aware of the medications he received each day.

During an interview on 11/07/24 at 2:44 PM Pharmacy Consultant #2 stated she conducted the admission medication reviews and not 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 11/20/2024

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 757	Continued From page 37 monthly Pharmacy reviews. She stated according to Resident #59's medical record there had been no change in the frequency of the Hydroxyzine order. She stated the order should have been entered to administer as needed but it looked as though it had been scheduled instead. She reported that she didn't catch the frequency error on the admission review. She stated Hydroxyzine 25 milligrams was not a high dose and it was short acting and would only be effective a maximum of 4 hours. She stated it was administered nightly at bedtime so Resident #59 would most likely sleep through it, and the medication would be completely out of his system by the next morning. She stated it would cause no harm to Resident #59. During an interview on 11/08/24 at 10:15 AM the Director of Nursing stated it appeared that the medication order for Hydroxyzine 25 milligrams was entered to administer nightly instead of as needed for Resident #59. She stated the medication order should have been entered accurately. She reported that education would be provided to nursing staff regarding entering medication orders accurately.	F 757		
F 842 SS=B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.	F 842		12/18/24

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 11/20/2024

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 842	Continued From page 38	F 842		

§483.70(h) Medical records.
§483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(h)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when

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 11/20/2024

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 842	Continued From page 39 there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interviews the facility failed to maintain complete medical records in the area of medication administration. This occurred for 3 of 5 residents (Resident #36, Resident #38 and Resident #54) reviewed for medication administration. Findings included. 1.) Resident #36 was admitted to the facility on 08/16/22 with diagnoses including hypertension, hypocalcemia, constipation, anxiety and depression. Review of the Medication Administration Record (MAR) dated October 2024 for Resident #36 revealed the following medications with dates and time were not signed off as administered by Nurse #13: Amitiza oral capsule 24 micrograms. Give 1	F 842	1. Licensed Nurse reviewed the Medication Administration Record for RI #36, 38, and 54 and medication was documented as administered on 12/12/24. Additionally, the Treatment Administration Record was reviewed for RI #54 and treatments were documented as provided on 12/12/24. 2. The facility has determined that all residents have the potential to be affected. 3. The Nurse Practice Educator and/or designee will educate Licensed Nurses on maintaining accurate and complete resident records by 12/17/24. 4. Beginning 12/16/24, the Nurse Managers and/or designee will audit 5 residents for completion of Medication	

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 11/20/2024

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 842	Continued From page 40 capsule by mouth two times a day for constipation was not signed off as administered by Nurse #13 at 5:00 PM on 10/22, 10/26, 10/27, and 10/31/24. Sevelamer Carbonate tablets 800 milligrams. Give 1 tablet by mouth with meals for hypocalcemia was not signed off as administered by Nurse #13 at 5:00 PM on 10/22, 10/26, 10/27, and 10/31/24. Carvedilol oral tablet 25 milligrams. Give 0.5 tablets by mouth two times a day for hypertension was not signed off as administered by Nurse #13 at 5:00 PM on 10/22, 10/26, 10/27, and 10/31/24. Nifedipine 90 milligrams extended-release tablets. Give 1 tablet by mouth one time a day for hypertension was not signed off as administered by Nurse #13 at 5:00 PM on 10/22, 10/26, 10/27, and 10/31/24. Colace capsule 100 milligrams. Give 1 capsule by mouth two times a day for constipation was not signed off as administered by Nurse #13 at 5:00 PM on 10/31/24. Ferrous Sulfate tablet 325 milligrams. Give 1 tablet by mouth two times a day for iron supplementation was not signed off as administered by Nurse #13 at 5:00 PM on 10/31/24. Review of the Medication Administration Record (MAR) dated November 2024 for Resident #36 revealed the following medication with the date and time was not signed off as administered by Nurse #13.	F 842	Administration Records and Treatment Administration Records twice weekly for eight weeks, and then weekly for four weeks to ensure resident records are complete. The Director of Nursing Services and/or designee will review the results of these audits in the Quality Assurance Performance Improvement Committee for one quarter to ensure substantial compliance has been achieved and sustained. Subsequent plans of corrections will be implemented as necessary	

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 11/20/2024

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 842	Continued From page 41	F 842		

Depakote delayed release 250 milligrams. Give 1 tablet by mouth three times a day for mood was not signed off as administered by Nurse #13 at 2:00 PM on 11/04/24.

Multiple attempts were made to contact Nurse #13 on 11/07/24 and 11/08/24. There was no response.

During an interview on 11/08/24 at 2:12 PM the Director of Nursing (DON) stated she was not aware the medications for Resident #36 were not signed off on the MAR by Nurse #13. She reported that she had made several attempts to contact Nurse #13 and had no response.

2.) Resident #38 was admitted to the facility on 04/10/24 with diagnoses including hypertension, and diabetes.

Review of the Medication Administration Record (MAR) dated October 2024 for Resident #36 revealed the following medications with dates and time were not signed off as administered by Nurse #13:

Carvedilol 25 milligram tablets scheduled for administration at 5:00 PM was not signed off as administered by Nurse #13 on 10/26, 10/27, and 10/31/24.

Insulin Lispro 100 units per milliliters inject per sliding scale subcutaneous before meals and at bedtime for diabetes. No blood sugar result or insulin administration per sliding scale was signed off as obtained and administered by Nurse #13 at 11:30 AM on 10/13/24 and at 4:30 PM on 10/26, 10/27, and 10/31/24.

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 11/20/2024

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 842	Continued From page 42	F 842		

Megestrol Acetate 40 milligrams per 10 milliliters suspension. Give 5 milliliters twice daily for poor appetite scheduled for administration at 4:00 PM was not signed off as administered by Nurse #13 on 10/26, 10/27, and 10/31/24.

Review of the Medication Administration Record (MAR) dated November 2024 for Resident #38 revealed no blood sugar result or insulin administration per sliding scale was signed off as obtained and administered by Nurse #13 at 11:30 AM on 11/04/24.

During an interview on 11/08/24 at 2:12 PM the Director of Nursing (DON) stated Nurse #13 was an agency nurse. She stated Nurse #13 should have signed off on the MAR that the medications were or were not administered and should have checked Resident #38's blood sugar, recorded the result and administered insulin according to the physician orders. She stated she was aware there were issues with documentation of medications on the MAR's. She reported education would be provided to all nursing staff on medication administration and documentation.

3. Resident #54 was admitted on 11/15/22 with diagnosis which included bilateral above the knee amputations and paraplegia (paralysis affecting the trunk, abdomen and lower extremities).

Review of Resident #54's electronic health record revealed the following physician orders for wound care:

A 5/15/24 order to cleanse the stage 4 wound to the sacrum (the area at the base of the spine) with quarter strength sodium hypochlorite solution and pat dry. Apply calcium alginate with silver to

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 11/20/2024

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 842	Continued From page 43	F 842		

the wound bed and foam silicone border twice daily.

An 8/13/24 order to cleanse the left buttocks and right buttocks stage 4 wounds with quarter strength sodium hypochlorite solution and pat dry. Apply calcium alginate with silver to wound bed and foam silicone border twice daily.

Review of Resident #54's October 2024 Treatment Administration Records (TAR) revealed there was no electronic documentation of the physician ordered wound care treatments to the sacrum, right and left buttock on the following dates: 10/2/24 9:00 PM, 10/10/24 9:00 PM, 10/11/24 9:00 PM, 10/13/24 9:00 PM, 10/16/24 9:00 PM, 10/18/24 9:00 AM, 10/26/24 9:00 AM, 10/27/24 9:00 AM, 10/28/24 9:00 PM.

An interview was conducted with Nurse # 9 on 11/6/24 at 9:30 AM. Nurse #9 stated she worked on the 7:00 PM to 7:00 AM shift and was assigned to Resident #54 on 10/13/24. Nurse #9 indicated she was responsible for the ordered wound care treatments on her shift. Nurse #9 was unable to recall if she completed the ordered wound care treatments for Resident #54 on 10/13/24 at 9:00 PM. Nurse #9 indicated she should have documented if the wound care treatments were completed or if there was a reason why it was not completed.

An interview was conducted with Nurse #8 on 11/6/24 at 2:30 PM. Nurse #8 stated he worked the 7:00 AM to 7:00 PM shift and was assigned to Resident #54 on 10/18/24 from 7:00 AM to 7:00 PM. Nurse #8 stated he did not know why the wound care was not signed for on 10/18/24 at 9:00 AM. Nurse #8 stated he was aware that it

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 11/20/2024

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 842	Continued From page 44	F 842		

was important to document the care that was provided.

An interview was conducted with Nurse #6 on 11/7/24 at 11:20 AM. Nurse #6 stated she was scheduled on 10/2/24, 10/10/24, 10/11/24, 10/16/24, and 10/28/24 on 7:00 PM to 7:00 AM shift and was assigned to Resident #54. Nurse #6 stated Resident #54 had serious wounds with wound care orders to be completed on the 7:00 PM to 7:00 AM shift. Nurse #6 stated she did not recall why she did not electronically sign the TAR for the ordered wound care treatments.

Attempts were made via phone to interview Nurse #7 during the survey with no return call received. Nurse #7 was assigned to Resident #54 on 10/26/24 and 10/27/24 from 7:00 AM to 7:00 PM.

An interview was conducted on 11/7/24 at 11:47 AM with the Nurse Practitioner (NP). NP stated documentation in the medical record should be accurate and the Treatment Administration Records were reviewed by herself and the physician to evaluate care and determine changes. NP indicated she was not aware of any inaccuracies on Resident #54's TAR.

An interview was conducted with the Director of Nursing (DON) on 11/7/24 at 2:30 PM. The DON indicated she was an agency DON that started in the position in October 2024. The DON stated she expected the nurses to accurately document the physician ordered wound treatments on the TAR. The DON indicated accurate documentation was important for evaluation of care and treatment. The DON stated there were issues with inaccuracies in documentation and she would address this with the nurses.

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 11/20/2024

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 849 SS=D	Hospice Services CFR(s): 483.70(n)(1)-(4) §483.70(n) Hospice services. §483.70(n)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(n)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure	F 849		12/18/24

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 11/20/2024

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 849	Continued From page 46	F 849		

that the needs of the resident are addressed and met 24 hours per day.
(E) A provision that the LTC facility immediately notifies the hospice about the following:
(1) A significant change in the resident's physical, mental, social, or emotional status.
(2) Clinical complications that suggest a need to alter the plan of care.
(3) A need to transfer the resident from the facility for any condition.
(4) The resident's death.
(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.
(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.
(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.
(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and

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 11/20/2024

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 849	Continued From page 47	F 849		

delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.
(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

§483.70(n)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.
The designated interdisciplinary team member is responsible for the following:
(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.
(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related

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 11/20/2024

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 849	Continued From page 48	F 849		

conditions, and other conditions, to ensure quality of care for the patient and family.
(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.
(iv) Obtaining the following information from the hospice:
(A) The most recent hospice plan of care specific to each patient.
(B) Hospice election form.
(C) Physician certification and recertification of the terminal illness specific to each patient.
(D) Names and contact information for hospice personnel involved in hospice care of each patient.
(E) Instructions on how to access the hospice's 24-hour on-call system.
(F) Hospice medication information specific to each patient.
(G) Hospice physician and attending physician (if any) orders specific to each patient.
(v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.

§483.70(n)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24.

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F 849	Continued From page 49 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to maintain communication and coordination of services provided by Hospice in the medical record for 1 of 1 resident reviewed for Hospice services (Resident #41). Findings included: Review of the Nursing Facility Hospice Services Agreement signed 08/19/17 revealed the following: Manner of Communication: The Hospice Designee contact information and Resident Patient care information shall be provided to Nursing Facility by Hospice at the time a Resident Patient is admitted to Hospice. A cover sheet will be placed in the Resident Patient ' s chart indicating the contact information for the Hospice Designee. All communications between the Hospice and Nursing Facility pertaining to the care and services provided to the Resident Patient shall be documented in the Resident Patient's clinical record. Resident #41 was admitted to the facility on 02/06/23 with diagnoses that included atherosclerosis heart disease of the native coronary artery without angina (chest pain). Review of a quarterly Minimum Data Set assessment dated 08/03/24 documented Resident #41 received Hospice services while a resident. Review of the care plan dated 08/26/24 for Resident #41 documented a Hospice start date of 12/05/23 due to end stage diagnosis of CAD (coronary artery disease). Community Hospice	F 849	1.Social Service Director and/or designee obtained hospice records for RI #41 and placed hard copy documents at the nurse□s station by 12/13/24. 2. The Social Services Director reviewed residents receiving hospice services to ensure documentation was in place by 12/14/24. 3. The Nurse Practice Educator and/or designee will educate Licensed Nurses and the Social Service Director on hospice communication and coordination of services by 12/17/24. 4. Beginning 12/16/24, the Social Service Director and/or designee will audit 5 residents receiving hospice services twice weekly for eight weeks, and then weekly for four weeks to ensure hospice communication and coordination of services. The Director of Nursing Services and/or designee will review the results of these audits in the Quality Assurance Performance Improvement Committee for one quarter to ensure substantial compliance has been achieved and sustained. Subsequent plans of corrections will be implemented as necessary	

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F 849	Continued From page 50	F 849		

start date was 12/5/23. Goals included: Hospice will provide support for coping with grief/loss; the resident will be comfortable throughout the end of life journey as evidenced by absence of pain or shortness of breath; the resident will achieve the highest possible level of acceptance and readiness for death by the time of death as evidenced by the absence of restlessness or agitation; and the resident will achieve the highest possible level of peace by the time of death as evidenced by demonstrating healthy coping mechanisms. Interventions included to assess the resident for pain/restlessness/agitation/constipation and other symptoms of discomfort; medicate as ordered and evaluate effectiveness; provide non-pharmacological approaches to aide in decreasing discomfort; bereavement service provided by Hospice as needed to help with grief and loss/support to the resident and family including caregivers and other residents before and after death; the facility will notify Hospice of significant changes/clinical complication needing a plan of care change and the need to transfer the resident or the resident ' s death. Resident code status of DNR (Do Not Resuscitate). Hospice Nursing 4 x per week x 1 week, 3 x week x 1 week, 2 x per week x 11 weeks and as needed to assess and manage symptoms, comfort/pain, bowel function and management of any other present cardiac symptoms. Hospice Nursing Assistant 2 x per week x 1 week, then 5 x per week to compliment activity of daily living care, provide comfort and companionship. Hospice Social Work 2 x per month and as needed to provide psychosocial support related to end of life care. Staff will provide emotional and social support to the resident and family to address anticipatory grief, end of life

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F 849	Continued From page 51	F 849		

wishes/planning needs and other identified items.

Record review of the resident's electronic medical record revealed the following documentation was absent: Hospice agreement, provider order and certification for services, care plan, and visit notes (nursing, social work, and clergy). In addition, there were no hard copy documents located at the nursing station.

In an interview with the Social Worker on 11/6/24 at 9:50 AM she stated it had been an "uphill battle" to get the Hospice provider to provide documentation for the medical record. She had been requesting a binder with documentation that included the Hospice Certification, care plan and progress notes. She stated she would contact the Hospice provider again in an effort to obtain the documentation. In an additional interview on 11/08/24 at 10:09 AM she stated she had asked the Hospice provider for the residents' progress notes but had not received any. She reported she had placed calls to the Hospice Director twice this week and had worked out an agreement for their lesion to bring the progress notes and other documents to the facility and maintain a folder at the nursing station to improve communications. She stated the Hospice Director had agreed to attend a "Journey Meeting" on 11/17/24 to discuss what was and was not working related to the care of Hospice residents and the services Hospice provided.

In an interview with the Unit Manager on 11/6/24 at 11:10 AM she stated there were Hospice documents in a box in medical records. An observation of the "Hospice box" located under shelving in medical records was conducted during the interview. A plain white box with no

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F 849	Continued From page 52	F 849		

identification was pulled out from under a shelving unit by the Unit Manager. The box contained several different Hospice care plans from different Hospice providers not sorted in any particular way. The Medical Records Clerk, who was also present, stated she was only one person and could not get everything scanned into the computer. She commented if any staff member wanted to look at the Hospice care plans, they could look in the box. The Unit Manager added that all Hospice providers who came to the building carried a tablet that facility staff would initial when the provider arrived and departed. The Unit Manager stated if there were any updates regarding resident care, the Hospice Nurse would advise her verbally.

In an interview with the Administrator on 11/08/24 at 10:30 AM she stated that Hospice had stopped bringing documentation to the facility but did not know why. She confirmed that a meeting had been scheduled for 11/17/24 to resolve the communication issues. The Administrator stated the meeting would include the Hospice Director and the facility interdisciplinary team.